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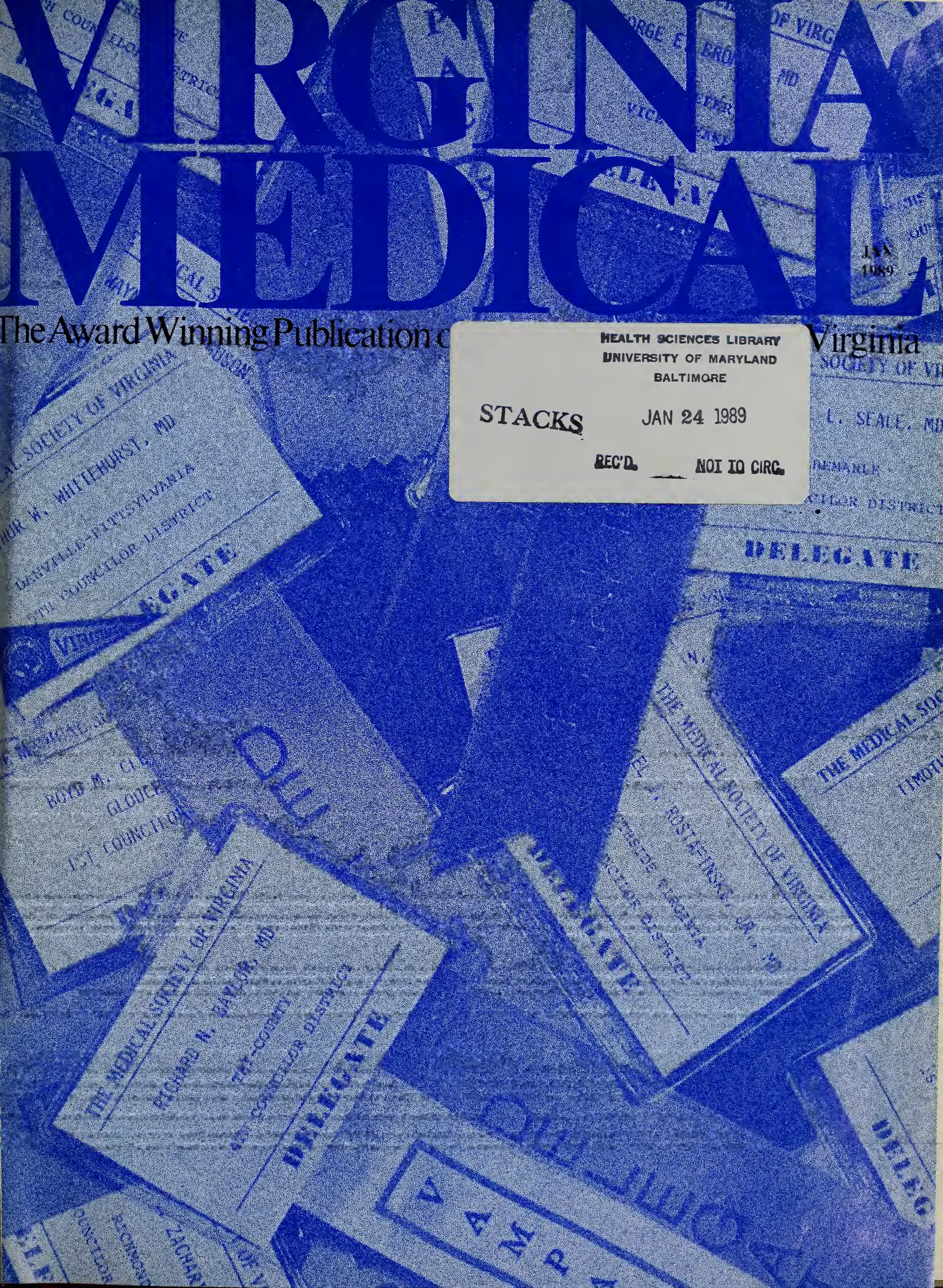

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KEY TO ABBREVIATIONS

b—book review
cr—committee report
ed—editorial
h—history
in—interview
le—letter to editor
m—memoir
*—medical article
mb—medibytes
par—public affairs report
pv—point of view
s—speech
sa—special article
ww—who's who

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DESIGNED FOR: Internists and interested primary care physicians

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DATES: July 21-23, 1989 LOCATION: The Ramada Oceanside Tower Resort, Virginia Beach, VA
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DESIGNED FOR: Primary care physicians

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DATES: August 25-27, 1989 LOCATION: Virginia Beach Resort and Conference Center
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INSURANCE

Why's, Wherefore's, and What to Do about Soaring Health Plan Rates

Ira D. Godwin, MD, Chairman, Insurance Committee

For over 25 years, the Medical Society of Virginia has endorsed a Virginia Blue Cross/Blue Shield health insurance plan for its members and their families and staff. The currently endorsed plan is known as the Virginia Physician's Plan. It is a full-service health insurance plan. In addition to MSV members, participating physicians of Virginia BC/BS and their families and staff are also covered.

The plan's premiums increased in 1988 by only 8.7%, of which 1.5% was due to improving outpatient mental health coverage from 50/50 copay to 80/20. Most subscribers were not unhappy with that increase.

Unfortunately, the plan experienced heavy usage in the period 9/1/87-8/31/88, with incurred claims ($9,720,119) greater than premiums ($9,251,199). When Virginia BC/BS projected the increasing costs of the plan, including pooling of excess claims, state premium tax, and administration/contingencies, they proposed a rate increase for 1989 of 46.4%. This proposal shocked the Insurance Committee and Council.

After exhaustive discussions with Virginia BC/BS, it was decided to increase certain deductibles in an effort to hold the premium increases down. The Comp Care 100 plan has been changed to Comp Care 200 to reflect the individual calendar year deductible increase to $200; also, the individual out-of-pocket limit has been increased from $1,000 to $1,500.

For both Comp Care 200 and Comp Care 500 (also individual calendar year deductible of $200), the in-hospital deductible has been increased from $100 to $200 per confinement and the PRN drug card deductible per prescription has been increased from $2.50 to $3.50 for a generic drug and from $4.50 to $7 for a brand name prescription.

With these changes, the Comp Care 200 premium will be 37% greater than the 1988 Comp Care 100 premium, and the Comp Care 500 premium will increase by 44%. The Insurance Committee regrets that it could not keep the premium increases lower, but these are the best rates that Virginia BC/BS would give us. Most health insurance plans are having large increases at this time, although ours is more than most.

At its November 2, 1988, meeting, Council accepted the Insurance Committee's recommendation that the Society accept these premium increases in its endorsed plan. The Council was distressed at the size of the premium but felt that it must offer this plan to members who cannot get other acceptable health insurance.

The new rates became effective on January 1, 1989.

WHY is this plan so expensive in comparison with other plans? First, because this plan has excellent coverage. When compared item by item with other plans, coverage of this plan is usually better.

Second, because its issue is guaranteed. It has been Medical Society of Virginia policy that its sponsored health insurance plan must be available to all members, regardless of their health. This means those who cannot get health insurance elsewhere can buy into this plan.

Third, because excellent coverage and guaranteed issue lead to much higher usage and cost than for other kinds of plans. Also, this plan's subscribers probably are the most sophisticated users of medical care in the entire state.

Fourth, because of adverse selection. Although the survey the Insurance Committee did last year showed that good coverage was generally more important to the plan's subscribers than cost, many physicians and their staffs are more interested in lower premiums. This is particularly true if they are in good health. Therefore, more and more of them opt out of this plan. This in turn causes the premiums to continue to rise at a faster than average rate.

WHAT can be done to decrease the costs of this plan? We could increase the deductibles even more, decrease some of the benefits, or go to a "managed care" plan. Adoption of managed care for

this plan would have reduced the premium by 5.2%. Your Insurance Committee intends to explore these options in the coming year.

What should MSV members do? If this plan is best for your particular circumstances, buy it. If you have some hesitancy, shop around. You may be able to find another Virginia BC/BS plan; you may qualify for their healthy Virginian plan. The Medical Society of Virginia has endorsed a health insurance plan with Pearl & Associates which has deductibles of $1,000 and $2,000; this plan is not truly comparable in benefits with the Virginia Physician's Plan, but you may prefer it.

Address correspondence to Dr. Godwin at PO Box 188, Fairfax VA 22030. These members serve with him on the Insurance Committee: Dr. Lawrence E. Blanchard III and Dr. Owen W. Brodie, both of Richmond; Dr. Williams S. Burton, Nassawadox; Dr. John L. Dobson, Virginia Beach, and Dr. J. William Giesen, Radford.

SAFE DRIVERS

If one of your patients persists in driving despite your warnings not to, ask Dr. Howard M. McCue, Jr., for help. He is staff physician at the Department of Motor Vehicles, where there is a Medical Control Unit to handle these cases. A state law now protects you from 1) disclosure and 2) legal action. Dr. McCue's address is PO Box 27412, Richmond VA 23229. His telephone number is (804) 367-6639.

Cyane Lowden

Eighteen years of devoted service to The Medical Society of Virginia ended this year when John Nash (left above) retired from his post as maintenance man and general assistant. "He did anything that was needed, and he always did it well and cheerfully," Executive Vice President Jim Moore (right above) told the MSV Council. As the councilors applauded, Nash accepted a check, then stayed one more time to supervise the serving of lunch.

Specify Adjunctive.

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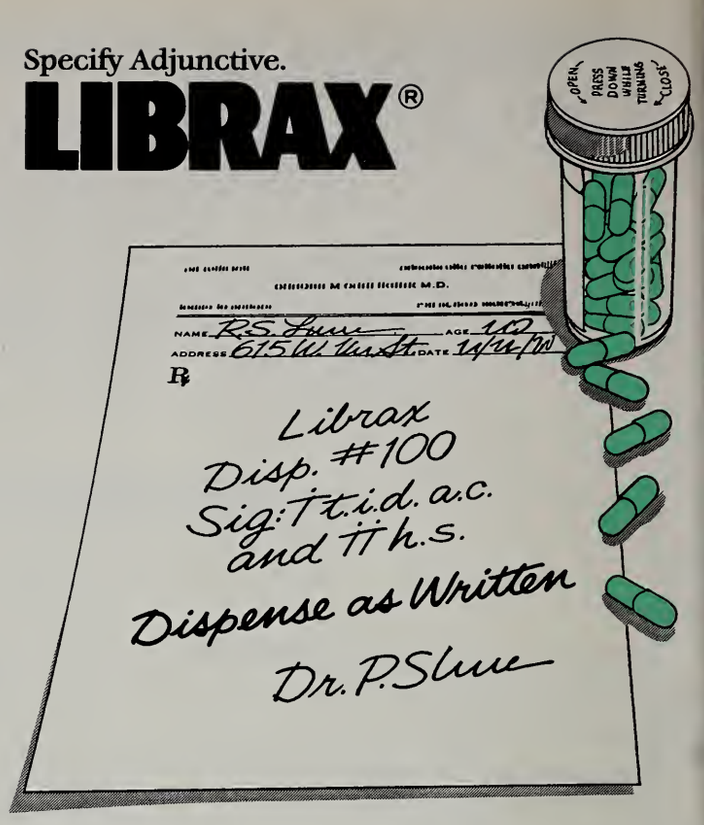

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.
Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).
Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**
As with all anticholinergics, inhibition of lactation may occur.
Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.
Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. After extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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141st Annual Meeting

Summarized in these pages are actions taken by the House of Delegates during its second session on November 5 during The Medical Society of Virginia's annual meeting in Williamsburg. Dr. Glenn B. Updike, Jr., was the presiding officer. Conducting the deliberations of the House were Dr. William H. Barney, Speaker, and Dr. George E. Broman, Vice Speaker.

Thomas L. Williams photographed the annual meeting.

Executive Editor Ann Gray wrote the report of the delegates' actions.

REFERENCE COMMITTEE ONE: Education and Interprofessional Relations

Eugene R. Lareau, MD, Chairman, Louis D. Parham, Jr., MD, James P. Baker, MD, Sam Barton, MD, Henry D. Patterson, MD, Jack C. Turner, MD, Daniel N. Mohler, Jr., MD, Carol S. Shapiro, MD, Frank Blanton, Jr., MD, Catherine S. Casey, MD, and Deborah Irr

Address of the President

The chairman reported that Reference Committee One urged adoption of the following recommendation made by Dr. Updike in his Presidential Address (see page 36): **That VaMPAC ensure that the Society's councilors and vice councilors, members of the MSV State Legislative Committee from the pertinent districts, and the Society's lobbyists are consulted before making candidate-support decisions.** The House adopted President Updike's recommendation.

On the recommendation of the Committee, the House then **elected Dr. Updike to honorary active membership in The Medical Society of Virginia.**

Aging

Agreeing with the Reference Committee's endorsement, the House adopted the following three recommendations from the Report of the Committee on Aging:

1) Encourage component medical societies to develop plans for voluntary programs for acceptance of Medicare assignments based on financial need; 2) designate the Committee on Aging and the MSV staff as resources for the programs; and 3) set January 1, 1990, as deadline for implementation of the programs.

Cancer

Reference Committee One asked for adoption of this amended version of a recommendation from the Report of the Cancer Committee:

"That The Medical Society of Virginia recommend to the General Assembly of Virginia the creation of programs of cytotechnology in appropriate health education centers, to be supported with adequate faculty, space and funding." The House so adopted.

Resolution C on mammography, introduced by the Alexandria Medical Society, called for The Medical Society of Virginia to encourage the General Assembly of Virginia to enact legislation mandating that health insurance cover screening mammography. A Supplemental Report from

the Cancer Committee described the proposed legislation.

Dr. Lareau reported to the House that Reference Committee One had heard testimony describing the advantages and disadvantages of mandatory insurance coverage of mammography. There was general accord, he related, as to the importance of mammography as a screening procedure and as to the need for improving the quality of the procedure and of archiving the results. There was concern, however, about the costs associated with mandating insurance coverage.

The Committee had also heard testimony, Dr. Lareau continued, that a member of the General Assembly, Delegate Bernard Cohen, was drafting legislation for introduction in the 1989 session that would mandate health insurance coverage of mammography.

Reference Committee One recommended **that the Cancer Committee work with the General Assembly in drafting legislation to ensure that it is responsive to the goals articulated in the report of the Task Force on Screening Mammography created by The Medical Society of Virginia in 1988,** and recommended accordingly that Resolution C be referred to the Cancer Committee.

Dr. C. M. Kinloch Nelson rose to suggest that the resolution be referred to Council, where it could be given more authoritative action, and offered an amendment to implement that suggestion. His amendment found favor and the amended recommendation **to refer Resolution C to the MSV Council** was adopted.

Dr. Sidney W. Tiesenga, Chesapeake

Highway Safety

The Highway Safety Committee's Report recommended **that riders of bicycles, mopeds and "off-road" motorcycles be encouraged to use safety helmets.** Reference Committee One recommended adoption and the House unanimously endorsed the recommendation.

Left to right, Dr. Alexander T. Ocampo, Fairfax, Dr. Andrew J. Sheridan, Arlington, and Dr. Rolando J. Santos, Springfield

Peer Review

On the Reference Committee's recommendation, the House adopted the following amended version of a recommendation from the Medical Society of Virginia Review Organization Oversight Committee:

That Medical Society of Virginia members of the MSVRO Board be instructed to institute the following procedures:

1) In Severity I Level cases, at least one physician of the specialty in question and of the same type of practice review the case where there is a question of quality of care.

2) In cases potentially of Severity II/III Level, two physicians of the specialty in question and of the same type of practice register unanimous agreement prior to referral to the Regional Review Committee.

3) The Quality Assurance Committee include three ad hoc members of the same specialty and type of practice as the physician or provider under investigation.

Reference Committee One recommended against adoption of Resolution O submitted by the MSVRO and calling for a change in the name of the organization, and the House followed the committee's lead. "The current name appropriately expresses the relationship between the two organizations," said the Committee's report as read by the chairman.

Rural Health

From the Rural Health Committee came a recommendation calling for The Medical Society of Virginia **to continue to support efforts to equalize payments by third-party payors to rural and urban hospitals and physicians.** Reference Committee One favored adoption of the recommendation, reported Dr. Lareau, but Dr. Richard L. Fields rose to ask that the recommendation **be referred to Council** for action. The recommendation was amended to include that

referral and was then adopted unanimously by the House.

Sheriffs Advisory

Two recommendations from the Report of the Sheriffs Advisory Committee were endorsed by the Reference Committee:

Resolution One called for **the discontinuation of the committee and formation in its place of a statewide organization of jail physicians.** Resolution Two provided for **the appointment by the President of The Medical Society of Virginia of a liaison committee from the new organization.**

Both recommendations were adopted by the House.

Sports Medicine

Three recommendations from the Sports Medicine Committee and Resolution D on Anabolic Steroids from the Fairfax County Medical Society were next considered in the report of Reference Committee One.

The first recommendation, as amended by the Reference Committee, read as follows: **RESOLVED, that The Medical Society of Virginia support efforts of the special state legislative subcommittee studying the use of anabolic steroids and endorse sending to schools in Virginia a survey regarding the use of anabolic steroids.**

On behalf of the 10th district delegation (Arlington and Fairfax), Dr. William J. Purkert rose to add to the end of the recommendation, **"and to keep studying this situation, especially in Virginia's high schools."** After voting in favor of Dr. Purkert's addition, the House then adopted the recommendation as amended.

The committee recommended **referral to the Society's State Legislative Committee** of the second recommendation from the Sports Medicine Committee. This recommendation called for The Medical Society of Virginia **to support legislation that would permit physicians to supervise licensed physical therapy assistants.**

"The Legislative Committee is now engaged in discussions with the physical therapists regarding areas of responsibility," Dr. Lareau read from the Reference Committee's report; hence the referral recommendation. The House voted so to refer.

The third recommendation from the Sports Medicine Committee had been amended by the Reference Committee. As presented to the House by Dr. Lareau, it read, **RESOLVED, that The Medical Society of Virginia support certification of athletic trainers in Virginia.** The recommendation as presented was adopted.

Resolution D asked for MSV liaison with state high school athletic associations to address the issues of anabolic steroids. The Reference Committee did not feel the resolution warranted adoption, reported the chairman, because "the first recommendation of the Sports Medicine Committee deals adequately with the subject."

Mental Health

As introduced by the Norfolk Academy of Medicine, Resolution B called for The Medical Society of Virginia to endorse legislation mandating reimbursement for an increased minimum of mental health services. "Your Reference Committee is concerned that this and other requests for increased insurance coverage could have a material impact on the cost of insurance and the willingness of employers to provide

Dr. Jeffrey W. Wilson, Roanoke, Chairman, Rules Committee

Dr. Vito A. Perriello, Jr., Charlottesville

Left to right, Dr. Timothy L. Kelly, Jr., Dr. Lawrence A. Gaydos, and Dr. Catherine S. Casey, all of Arlington

insurance coverage for their employees," said Dr. Lareau in presenting the committee's recommendation not to adopt. The House agreed and the resolution was lost.

Fraud/Abuse Clauses

From the Northern Neck Medical Society came Resolution V, dealing with third-party payor "fraud and abuse" clauses aimed at physicians. Reference Committee One had shortened the resolution as follows and recommended that the House adopt it: RESOLVED, **that The Medical Society of Virginia establish a physician/patient advocacy clearing house or respository for complaints, questions and concerns regarding third-party payors.** The House adopted the resolution as amended.

Death and Dying

Not recommended for adoption by Reference Committee One was Resolution W submitted by the Richmond Academy of Medicine; it was directed toward formation of an MSV committee to "study the issues of death and dying." The Reference Committee had heard testimony, said Dr. Lareau, that the Society's Ethics Committee is dealing with the important issues addressed in this resolution. The House did not adopt.

Consent Calendar

Recommended for filing by Reference Committee One were the reports of these committees: Education, Federal Legislative/Activities, Maternal Health, Mental Health, Public Relations and Rehabilitation; the Hospital Medical Staff Section; and commentary from the Report of Council on the MSVRO, the Aging Committee, and the nursing shortage.

Recommended for adoption:

1) **Council's rejection of Resolution S on Newborn Circumcision,** referred to it by the 1987 House of Delegates, on the grounds that "it is not the role

WINNERS

Delegate Clancy Holland sits with his 2nd district peers during the first session of the House. Behind him at right is Dr. Harry G. Plunkett, Norfolk.

As a page in the Virginia senate 44 years ago, **Clarence Adrian Holland** found his boyhood role model in the late Dr. James D. Hagood, whom he watched legislate effectively as a senator from Halifax County while continuing his general practice of medicine.[1]

Today Dr. Holland has an established general practice of his own and is entering his fifth year as state senator from Virginia Beach.

In 1968 Dr. Hagood received The Medical Society of Virginia's highest honor, the Physician Award for Community Service.

Twenty years later Clancy Holland became the 26th recipient of that same award, at ceremonies during the Society's annual meeting in Williamsburg.

Watching Dr. Hagood whetted Clancy Holland's appetite for public office, but it was his father who really got him started: The late Shirley T. Holland, an Isle of Wight Banker, served for 20 years in Virginia's House of Delegates. One of Clancy's two brothers, Richard J. Holland, is today the senator from the Isle of Wight. The other brother joined Clancy in medicine; he is Dr. William E. Holland, Richmond cardiologist. (Not related to the three brothers is another state senator, Edward M. Holland of Arlington.)

For 12 years Clancy Holland was a member of the city council of Virginia Beach (during the same period he was president of the Virginia Beach Medical Society), and in 1976 he was elected the city's mayor. In a highly effective two-year term, Mayor Holland instituted a tourist and industrial development department, gave strong support to education, including Eastern Virginia Medical School, and developed volunteer

of the Society to rule whether or not a certain medical procedure is appropriate."

2) Resolution I on the Good Samaritan Law, introduced by the Virginia Chapter, American Academy of Pediatrics, and the Virginia Pediatric Society, as follows: RESOLVED, **that The Medical Society of Virginia support passage by the Virginia General Assembly of legislation, such as has been enacted in Ohio, Kansas, Missouri and Tennessee, to expand our present Good Samaritan Law to include protection for volunteer medical personnel at scholastic and community athletic events.**

3) Resolution on Dissemination of Information Regarding Healthcare Costs, introduced by the Richmond Academy of Medicine, as follows: RESOLVED, **that The Medical Society of Virginia, in consultation with representatives of the insurance industry, government and business, develop educational programs to keep physicians informed regarding details of various healthcare plans developed by these institutions; and . . . continue to maintain an active role in representing physicians and patients of the Commonwealth in the development of healthcare plans and programs.**

4) Resolution T on Proposed Information Requirement for "Life-Threatening" Findings, introduced by the Virginia Beach Medical Society, as follows: RESOLVED, **that The Medical Society of Virginia oppose HB1036, which would require that radiologists inform patients of "life-threatening" findings; and . . . that members of the House Committee on Health, Welfare and Institutions be informed of the opposition of the Society to this bill; and . . . that the MSV State Legislative Committee be directed to use its best efforts in opposing this bill.**

emergency medical services. In 1981 he was chosen King Neptune of the Virginia Beach Neptune Festival, a title honoring civic achievement within the Tidewater community.

Dr. Holland also supports the arts in his hometown; he currently serves on the executive committee of the Virginia Beach Arts Center and the board of trustees of the Virginia Marine Science Museum.

At the state legislature in Richmond, his appointments include the Senate Committees on Education and Health, on Rehabilitation and Social Services, and on Privileges and Elections.

Carefully even-handed in an arena redolent of self-interest, Senator Holland nevertheless manages to be a cogent ally of The Medical Society of Virginia's lobbying efforts while the General Assembly is in session. He keeps an eye on the bills in progress, sharing information with the lobbyists so that they can "go out and touch everybody," as one legislator described it.[2] During the 1987 session he steered the Vaccine-Related Injury Act through both Senate and House so adroitly that there wasn't a dissenting vote.

Long a supporter of the Virginia Medical Political Action Committee, Clancy is now VaMPAC's vice chairman. He is a working member of the Society's Federal Legislative and Activities Committee, special advisor to the State Legislative Committee, and is on call to attend meetings of other committees grappling with legislative concerns. Typically, he sits attentively in these meetings until asked to speak, then deferentially offers information or suggestions.

On the hustings, he's an ebullient man with a big, big smile, accessible to all sorts and conditions of men, hospitable to all shades of opinion, susceptible to human frailty and distress.

"I believe we are put on this earth to help each other," he has said, "and I like to feel I'm doing a service."[1] MSV President Glenn B. Updike, Jr., confirmed Dr. Holland in that feeling as he presented him with the Community Service Award.

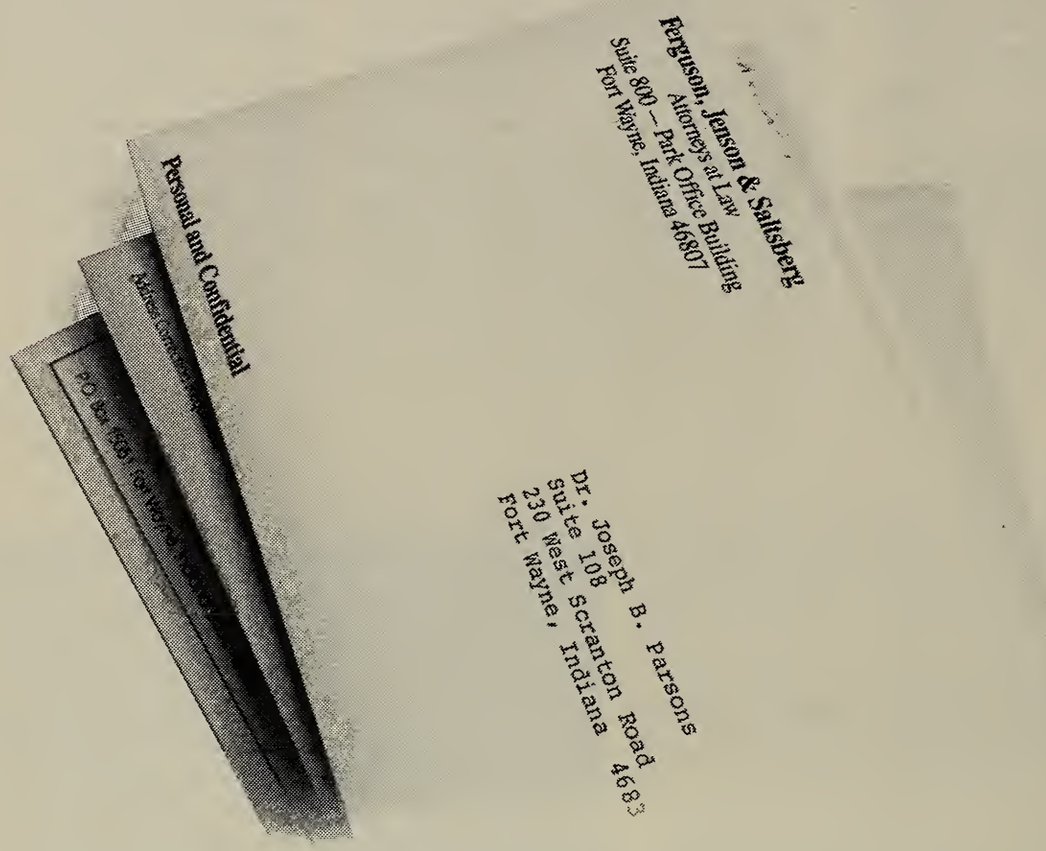
Clancy Holland, said Dr. Updike, is "a physician who has given not just 100% but 110%, to his patients, his community, and most of all, to us, his fellow physicians."

To **Dr. William A. Shaver,** Roanoke, went the blue ribbon for the scientific exhibit adjudged best of show; his topic, "Gastrostomy, a Simple and Effective Technique for Decompression and Feeding." Second place went to the American Cancer Society, Virginia Division, for its exhibit on the manifestations of oral cancer. The yellow ribbon for third was pinned on the exhibit displayed by **Dr. Ted Dupuy,** Chesapeake, whose text and pictures elucidated "A New Semi-Supine Oblique Radiographic View of the Hook of the Hamate."

In the golf tourney, **Dr. C. B. Courtney, Jr.,** Newport News, tallied the lowest gross score for the 18-hole round and took home the Challenge Cup. Not enough players signed up to make a tennis tourney.

Dr. George R. Smith, Jr., Shawsville, and **Dr. Harvey D. Smallwood,** Charlottesville, won the copies of *Dorland's Illustrated Medical Dictionary* contributed by the W. B. Saunders Company.

Crisis in black and white.



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REFERENCE COMMITTEE TWO: Legislation and Regulation

Antonio M. Longo, MD, Chairman,
Robert T. Davis, MD, Russell D. Evett, MD,
Lawrence C. Zacharias, MD, George J. Carroll, MD,
Henry S. Campell, MD, William E. Painter, MD,
Joel R. Poole, MD, Beryl H. Owens, MD,
Richard E. Linde, MD, and Tracy Iezzi

Animal Research

The chairman reported that Reference Committee Two recommended for adoption an expanded version of Resolution G on the Use of Pound Animals for Research Purposes in Virginia Medical Institutions, introduced by the Virginia Chapter, American Academy of Pediatrics. The text was revised and endorsed by the Committee:

RESOLVED, **that The Medical Society of Virginia support enactment of legislation by the Virginia General Assembly that would require making available animals from pounds, after they have not been claimed by owners, for research purposes in medical schools in the Commonwealth of Virginia; and be it further**

RESOLVED, **that The Medical Society of Virginia adopt a policy encouraging voluntary health organizations, such as the state component associations of the American Cancer Society and the American Heart Association, to endorse publicly a position supporting the use of pound animals for research purposes in Virginia's medical schools; and be it further**

RESOLVED, **that The Medical Society of Virginia encourage methods of identifying and retrieving lost pets, such as registration and the use of tattoos, so as to facilitate their early identification and safe return.**

Dr. Longo told the delegates that Reference Committee Two heard testimony relating to legislation introduced in the last session of the Virginia General Assembly intended to severely restrict the use of pound animals for medical research. This legislation was carried over for consideration in the 1989 session, he noted, and in the interim was the subject of a legislative study and a source of public debate.

The Committee believes that animal research is essential to continue to find and improve methods of treating debilitating and deadly human disease, Dr. Longo continued, and heard testimony indicating that voluntary health organizations are in a good position to communicate the good that is derived from animal research in saving and improving the quality of human life. Accordingly, the Reference Committee added to the resolution the second resolved clause asking the Society to encourage such support.

But the Committee is sensitive to the concerns of pet owners that their pets not be the subject of such research, Dr. Longo emphasized, and for that reason its members added the third resolved clause to facilitate the early identification and safe return of lost pets.

The Speaker opened the subject for discussion, drawing negative comments from the floor on the use of the word "pets." The objections subsided, however, when the chairman reiterated the Committee's specific purpose in that part of the resolution—to indicate expressly that physicians do not want pets used in research.

After that point had been clarified, Dr. Donald S. Thorn rose to request the addition of another clause, namely, **"that The Medical Society of Virginia urge its members to contact their legislators and representatives in the Virginia legislature to urge their support of the Society's position."**

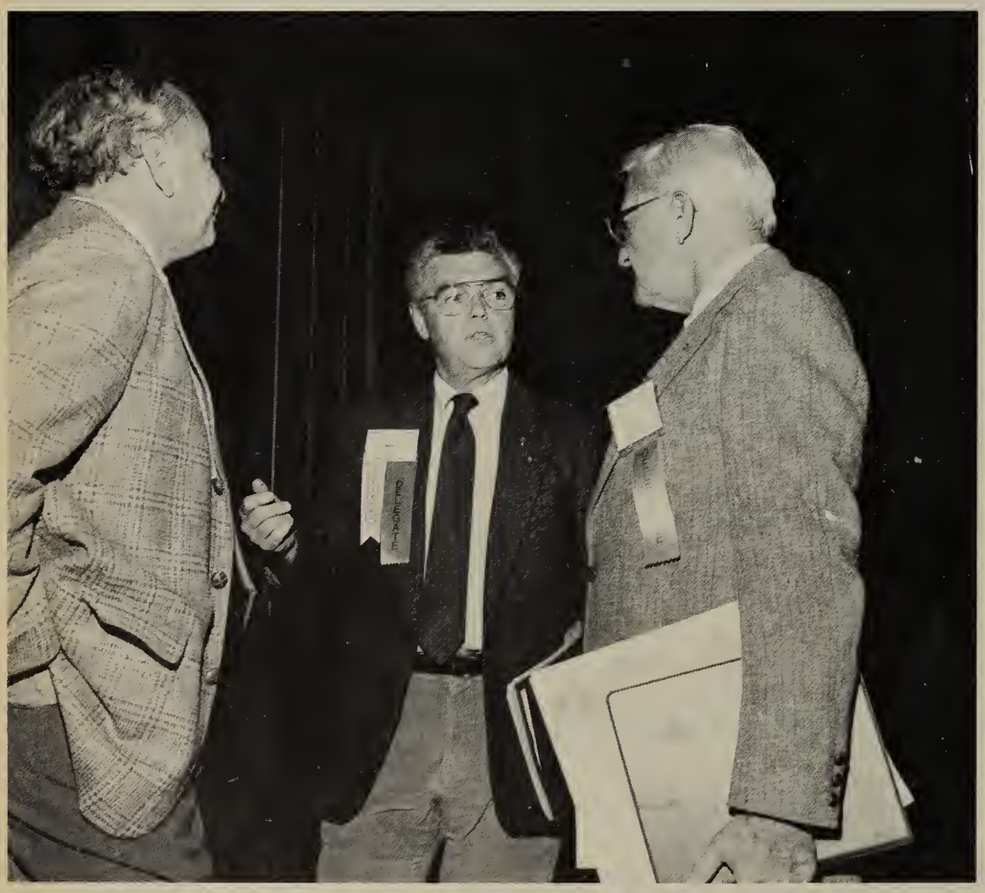
The House approved the addendum and then adopted the entire four-part resolution.

Information Sharing by BC/BS

The next recommendation made by Dr. Longo on behalf of Reference Committee Two arose out of the Committee's "extreme concern about the implications" of certain aspects of Blue Cross and Blue Shield of Virginia's use of its new insurance claim form. The Committee received at its hearing copies of a document entitled "Health Management Corporation—HMC Information Services for Hospitals," the chairman related, and also heard testimony expressing concern because the document seemed to indicate that BC/BS intends to share proprietary physician information with its affiliate, Health Management Corporation, without the knowledge or consent of physicians. Additional testimony, said Dr. Longo, indicated that HMC apparently intends to develop individual physician profiles from such information, which it intends to sell or otherwise make available to hospitals and other employers. The Reference Committee was disturbed by the implications of such data collection and dissemination, Dr. Longo said, particularly "the prospect of such activity without the knowledge or consent of physicians, who intend merely to provide information to Blue Cross and Blue Shield so as to obtain payment for services performed." Accordingly, he concluded, the Committee offered the following recommendation:

RESOLVED, **that the House of Delegates instruct Council to investigate and take appropriate and prompt action responding to the apparent intention of Blue Cross and Blue Shield of Virginia to share physician claims in-**

Dr. Warren W. Koontz, Jr. (left), Richmond, and Dr. Robert F. Baxter, Grundy



From left, Dr. John R. Hogg, Newport News, Dr. Robert T. Mosby, Virginia Beach, and Dr. Jefferson D. Beale, Jr., Danville

formation with its affiliate, Health Management Corporation, thus enabling Health Management Corporation to develop and release individual physician profile data to hospitals and employers.

The House swiftly adopted the recommendation, and on the motion of Dr. Charles M. Caravati, Jr., the MSV staff was instructed to send to all the delegates copies of the document referred to by Dr. Longo.

Professional Liability

Observing that "your Committee feels that physicians have behaved responsibly by helping to get the Injured Infant Program started through their contributions during its first two years of operation," Dr. Longo submitted Reference Committee Two's endorsement of these two recommendations:

1) **That The Medical Society of Virginia propose legislation to remove the $250 assessment from the Injured Infant Act.** This recommendation came from the Professional Liability Committee.

2) **That The Medical Society of Virginia urge the amendment of the mechanism of funding for the Virginia Birth-Related Neurological Injury Compensation Act to reflect contributions by all citizens of the Commonwealth of Virginia.** This recommendation was introduced by the Alexandria Medical Society.

Both recommendations were adopted unanimously.

Also endorsed by Reference Committee Two and unanimously adopted by the House were three other recommendations from the Professional Liability Committee, as follows:

1) **That The Medical Society of Virginia support efforts to study the Injured Infant Act and continue to look for alternatives to the tort system for settling liability disputes.**

2) **That The Medical Society of Virginia monitor closely and intercede where appropriate in the judicial determination of the constitutionality of the cap on medical liability awards.**

3) **That The Medical Society of Virginia oppose current efforts to liberalize the Statute of Limitations and standards of care.** Of this third recommendation, Dr. Longo said, "Your Committee wishes to note that it considers the Society's Expert Witness Program an appropriate way to respond to the concerns of plaintiffs' attorneys regarding the availability of medical experts who are familiar with the statewide standards of care, and wishes to encourage the Society to continue to look for ways to enhance the effectiveness of this program."

Therapeutics and Devices

Testimony at Reference Committee Two's hearing about patients ordering prescription medications by mail in order to receive discounts triggered the next recommendation submitted to the House by the chairman.

The Committee recommended **that the Therapeutics and Devices Committee be directed to consider any patient care or other problems arising from the practice of ordering prescription medications through the mail.**

"While the Committee is sympathetic to the interests of patients who wish to cut their health care costs," Dr. Longo explained, "it heard sufficient testimony regarding the potential for adverse quality of care to warrant further investigation by the Society."

"Your Committee also wishes to affirm the actions of the Therapeutics and Devices Committee," he added, "in its work with the Board of Pharmacy in seeking to ensure that physicians will continue to be allowed to administer medications in their offices without regulation by this Board."

Respiratory Therapy

From the Richmond Academy of Medicine came Resolution P on Mandatory Certification of Respiratory Therapists, which noted that the current program of voluntary

Dr. Jorge A. Naranjo, (left), Boykins, and Dr. Irwin H. McNeely, Franklin

From left, Dr. James P. Baker, Norfolk, Dr. Randall S. Suslick, Chase City, and Dr. Arthur S. Gear, South Hill

certification for respiratory therapists has elicited "poor enrollment" and asked The Medical Society of Virginia to support legislation to make certification mandatory.

Basing its conclusions on testimony at its hearing, Chairman Longo said, Reference Committee Two came to the conclusion that some different form of regulation may be in order to ensure that respiratory therapists are appropriately trained. The Committee felt, however, that mandatory certification might in effect be licensure and that would not be appropriate. Accordingly, the Committee offered the following modification of the resolution and recommended its adoption:

RESOLVED, **that The Medical Society of Virginia support legislation to create appropriate regulation of respiratory therapists in Virginia.**

The House adopted the Committee's version of the resolution.

Highway Safety

Taking up Resolution Q on Alcohol-Related Motor Vehicle Accidents, introduced by the Virginia Chapter, American College of Surgeons, Reference Committee Two recommended that the House adopt a slightly edited version as follows:

RESOLVED, **that The Medical Society of Virginia's Highway Safety Committee pursue expansion of the Norfolk Intoxicated Driver Study to all Level I Trauma Centers within the Commonwealth; and be it further**

RESOLVED, **that The Medical Society of Virginia support legislation facilitating the prosecution and removal of alcohol and/or drug-impaired drivers from the roadways of the Commonwealth; and be it further**

RESOLVED, **that a copy of this resolution be sent to the Governor of the Commonwealth.**

There was a request from the floor that copies of an article titled "Alcohol and the Motor Vehicle: a Social and Economic Dilemma," which was offered as supplemental information with Resolution Q, be sent to members of the General Assembly. This stipulation was inserted in the resolution's second clause, and the House then voted unanimously for adoption.

"We must constantly reach for agreement"

The Hon. Gerald L. Baliles, Governor of Virginia

My childhood impression of doctors was formed in the days of my growing up in Patrick County. They were people of integrity, decency and principle. And while so much else has changed, that has not. In fact, I hold to the view that the type of person drawn to the practice of medicine is driven far less by financial gain than by the desire to heal and to be independent.

The opportunity to heal remains—and the high quality of American medicine reflects that individual commitment. But, the aspiration for personal independence—a very American trait—is, for those who enter the medical professions, less easy to achieve. And for you, that may represent the greatest change of all.

In fact, I remember a few years ago, when a physician/crusader came to Richmond to lecture doctors on the benefits of forming a union. When I heard that he filled the main hall of the Richmond Hyatt Hotel with Virginia doctors to talk about unionism, I said to myself, "Something has changed here."

Well, I do not expect to see the union label show up in the local clinic anytime soon, but I do recognize your anxieties over the future, and as someone who has spent a lifetime in public service, I can appreciate your feelings.

Things *are* changing very quickly. Even in Virginia, a prosperous state, we see the Medicaid budget increasing at twice the rate of the state budget. In fact, Medicaid—now approaching expenditures of $1 billion annually—is already the second largest single line in the state budget, yet Virginia is regarded by some as one of the more parsimonious states in its allocations to the program. So, just as Congress has taken a great interest in your profession, so, too, must Virginia.

Generally, one of the more common declarations in politics is the call to work together. Given the diversity of our country, it is a call heard often. But in the case of health care, it could not be more true—because, in the past, there have been times when doctors and government worked at odds.

It comes down to a matter of perspective. Do you take the long view or the short view? If influential physicians simply say "No" to every proposal—as many doctors did when faced with Social Security, Medicare, Medicaid, and DRGs—then, after a while, that influence will diminish. It is not an enviable position—but it is the inevitable result of a nation that paradoxically believes that high quality, low cost healthcare is a natural right.

So, again, we must work together. In fact—and this is my commercial for the evening—Virginia has a

Excerpted from Governor Baliles' address at the VaMPAC banquet honoring the memory of Dr. Leonard Weyl on November 3 in Williamsburg during The Medical Society of Virginia's annual meeting.

Conflicts of Interest

Recommended for referral to the State Legislative Committee was Resolution S on Conflicts of Interest in the General Assembly, introduced by Dr. Robert P. Nirschl.

Dr. William W. Regan, MSV councilor for the 3rd district, rose to express the opinion that the Council could better deal with such matters. The House agreed with him, voting to change the referral accordingly.

Freedom to Choose Physicians

Concerned about a recent memo to retirees in which state officials encouraged them to choose a physician participating in Medicare, the Lynchburg Academy of Medicine drafted Resolution Z about State Retirees and Their Choice of Physicians. Reference Committee Two deleted one clause and added some language to the other, endorsing the following amended resolution for affirmative House action:

RESOLVED, **that The Medical Society of Virginia encourage the Commonwealth of Virginia to develop a health insurance package for its retirees that includes benefits for physicians' services and which allows freedom of choice of physician.**

From the floor came a request that the resolution be referred to Council for action and that the Council report back to the House at the 1989 annual meeting.

The House voted to amend the resolution to specify referral to Council and then adopted the measure as amended.

Consent Calendar

Recommended for filing were all or parts of the reports of these committees: AIDS, Animal Research, Insurance, State Legislation, Therapeutics and Devices, and VaMPAC, and items from the Report of Council dealing with animal research, on Medicare's "medically unnecessary" program, and on activities of the Legislative Committee.

Recommended for adoption:

1) Resolution F on Health Insurance Claims, introduced by the Richmond Academy of Medicine, which stated:

RESOLVED, **that The Medical Soci-**

splendid opportunity for you to do so.

As you may know, Virginia's rate of infant mortality has reached a new low—and that is very satisfying. Still, the rate remains too high. It exceeds the national average. So Virginia has launched the "BabyCare" program, which is Medicaid coverage for labor, delivery and prenatal care for all those women at or below the poverty level. With this program we believe we can reduce costs over the long haul, but Virginia needs widespread physician participation for the program to work, so I urge you to take part.

End of commercial.

I have enjoyed this evening—and I hope you will take my remarks in the spirit in which they are offered. America holds its doctors in high esteem. You are accorded great respect. You are influential and affluent. But America also subjects its doctors to enormous stresses and demands, and I cannot see where it is going to get any easier.

Despite the well-established American preference for individuality, our nation is still premised on our ability to draw our resources and our people together. We must constantly reach for that point at which we agree—for it is then that we achieve consensus and move ahead.

By the dedication of a lifetime to his profession and his Commonwealth, Dr. Weyl offers us an example. It is one that we would do well to remember.

Governor Baliles (right) is escorted through the crowd at the reception preceding the VaMPAC banquet by Dr. Clancy Holland.

ety of Virginia request the State Insurance Commissioner to study the feasibility of developing a standard claim form for the Commonwealth of Virginia; and be it further

RESOLVED, **that The Medical Society of Virginia encourage the Virginia General Assembly to enact legislation requiring insurers to pay interest at a competitive rate on those insurance claims that have been properly submitted and not paid within 25 days.**

2) Resolution R on All-Terrain Vehicles, introduced by the Virginia Chapter, American Academy of Pediatrics, and the Virginia Pediatric Society, concluding as follows:

RESOLVED, **that The Medical Society of Virginia support 1) a ban on the sale of all ATVs to, and use by, individuals under 16 years of age; 2) a ban on the recreational use of these vehicles on public land or on private land without the written consent of the property owner; and 3) a requirement for helmet use by all ATV riders; and be it further**

RESOLVED, **that The Medical Society of Virginia recommend passage of legislation by the Virginia General Assembly to require routine licensing of all ATV drivers above age 16.**

REFERENCE COMMITTEE THREE: Internal Affairs

John J. Krueger, MD, Chairman,
T. Eugene Temple, MD, C. M. Kinloch Nelson, MD,
Anthony J. Munoz, MD, Arthur W. Whitehurst, MD,
Robert L. Keeley, MD, Harvey D. Smallwood, MD,
Joseph V. Puglise, MD, William R. Deal, MD,
Barbara A. Mella, MD, and John Prahinski

Alternative Delivery Systems

Chairman Krueger began with a recommendation from the Committee on Alternative Delivery Systems, which asked for legislation to create a state health maintenance organization guaranty association. The Reference Committee believed the problem might be adequately addressed by the rules and regulations of the State Bureau of Insurance, Dr. Kreuger said, and amended the recommendation to read as follows:

RESOLVED, **that The Medical Society of Virginia investigate the need for a state HMO guaranty association.**

The Committee recommended that the House adopt the amended version, and the delegates did so.

Ethics

Reference Committee Three had reordered and amended the recommendations in the Report of the Ethics Committee, said Dr. Kreuger, and with some minor adjustments of language from the floor they were adopted by the House as follows:

1. That every medical and hospital staff should have written policy regarding No Code/Do Not Resuscitate orders using the following guidelines:

a) That every medical and hospital staff use a standard No Code/DNR order when it is intended that no CPR be given to a patient. Synonyms such as no heroics, comfort care only, chemical or pharmacological code, etc., should not imply No Code or DNR.

b) It should be clearly understood that the No Code/DNR order does not imply per se a lower or less aggressive standard of medical care of the patient, and the attending physician must write the order in the chart and give an adequate, though not necessarily lengthy, account in the progress notes regarding the reasons which led to the order.

c) That it is the physician's responsibility to eliminate any confusion among the nursing staff regarding the No Code/DNR order.

d) That the attending physician should always take pains to make sure that any No Code/DNR decision is in the best overall interest of the patient, and that both the decision and the reasons for it are clearly communicated to those who have a vital need to know.

2. That medical staff, hospital staff, and attending physicians familiarize themselves with the requirements of the Natural Death Act of Virginia and the significance of the Living Will (Code of Virginia 54-325.8:1) so as to be able to take advantage of the immunity from liability it provides in connection with the writing of No Code/Do Not Resuscitate orders.

Finances

The Reference Committee next recommended that the proposed budget for 1988-1989 be adopted as presented. It was so adopted and is published on page 32.

Ventilator-Dependent Patients

After considering the Richmond Academy of Medicine's Resolution A on Funding for Chronically Ventilator-Dependent Patients, the Reference Committee made some revisions, Dr. Kreuger reported. He offered these two clauses for adoption:

RESOLVED, **that The Medical Society of Virginia work to encourage the Commonwealth of Virginia to provide sufficient funding in the Medicaid program to make home care and nursing home care financially possible for ventilator-dependent patients; and be it further**

RESOLVED, **that The Medical Society of Virginia encourage other insurance carriers to make similar coverage available.**

The House adopted Resolution A as amended.

Child Health

As introduced by the Virginia Chapter, American Academy of Pediatrics, and the Virginia Pediatric

At the reception for new 50-Year Club members, Dr. Glenn B. Updike, Jr. (left), presents his certificate to Dr. DuPont Guerry III, Richmond.

Society, Resolution E on a Child Health Assurance Plan called for The Medical Society of Virginia to support legislation mandating a package of preventive health care services for children in every health insurance policy written in Virginia. Reference Committee Three endorsed the general intent of the resolution, but the Committee's members changed the specified package to an option and deleted a clause stipulating physician reimbursement at UCR levels; the changes were made, Dr. Kreuger stated, because the Committee was "concerned about cost and other implications of mandating such coverage."

Dr. Nicholas G. Colletti rose to advocate an alternative to the legislative route: Why not ask the Society simply to encourage all insurers to offer the package as an option? His motion so to amend was seconded and passed, and the resolution that follows was then adopted by the House:

RESOLVED, **that The Medical Society of Virginia encourage all medical insurers conducting business in the Commonwealth to offer as an option in every policy written a package of preventive healthcare services for children for at least the minimum of such care recommended by the American Academy of Pediatrics.**

Dues Reduction

The chairman announced that Reference Committee Three did not recommend adoption of Resolution J on MSV Dues Reduction, introduced by the Lynchburg Academy of Medicine, because, explained Dr. Kreuger, the Society's President and the Finance Committee had concluded such a step was not feasible. The resolution was lost.

RBRV Scale

"Your Reference Committee heard conflicting testimony on the concept of a cost- and resource-based relative value scale for physicians," said Dr. Kreuger, "and believes it has merit, as compared with other suggested alternatives, and that continued study and evaluation of this system would be appropriate." The Committee therefore rec-

MEDICAL SOCIETY OF VIRGINIA
BUDGET 1987-1988

Salaries	$470,000
Stationery and Supplies	18,000
Office Equipment: Repairs and Replacement	10,500
Building Expense	5,000
Telephone	18,000
Postage	24,500
Convention Expense	40,000
Council and Committee Expense	28,000
Delegates to American Medical Association	54,000
Staff Travel—AMA	3,700
President's Expense	14,000
Presidential Expense Allowance	15,000
President Elect Expense Allowance	3,000
Staff Travel Expense	
Preparation and Distribution of VIRGINIA MEDICAL	122,500
Editor, VIRGINIA MEDICAL	2,400
Legal Expense	110,000
Legislative Program	40,000
Walter Reed Commission	1,000
MSV Auxiliary	7,000
Membership Dues, Affiliated Agencies	1,200
Special Appropriations	
AMA/ERA	1,000
Scholarships	
Medical College of Virginia	1,000
University of Virginia	1,000
Eastern Virginia Medical School	1,000
Rural Health	1,000
Student Medical Societies	
Medical College of Virginia	3,500
University of Virginia	3,500
Eastern Virginia Medical School	3,500
Virginia Health Council	1,000
Hospital Resident Section	1,500
Other Special Appropriations	10,500
Insurance Premiums	14,500
Professional Liability and Tort Reform	60,000
Newsletter	6,000
Employee Benefits	
Retirement Fund	110,000
Blue Cross/Blue Shield, Life, and Disability	22,000
Payroll Taxes	34,000
Continuing Medical Education	18,000
Consulting Services	
Legislative and Public Relations	60,000
Insurance Actuary	10,000
Physicians' Health and Effectiveness Program	16,000
Miscellaneous	5,000
Computer Operation and Maintenance	6,000
Audit	8,000
TOTAL	$1,441,800

ommended adoption by the House of an amended version of Resolution K from the Virginia Society of Internal Medicine as follows:

RESOLVED, **that The Medical Society of Virginia support the continuing study and evaluation of a cost- and resource-based relative value scale for physician reimbursement.**

The House adopted the resolution.

MEDICAID

Dr. Kreuger described some revisions made by Reference Committee Three in Resolution M on Medicaid Reimbursement for Child Health Services, introduced by the Virginia Chapter, American Academy of Pediatrics, and the Virginia Pediatric Society.

He urged the adoption of the amended version as follows:

RESOLVED, **that The Medical Society of Virginia urge the Virginia General Assembly to enact legislation to improve access to child health services by increasing reimbursement for all such services.**

Resolution U, introduced by the Norfolk Academy of Medicine, also related to Medicaid. It referred to the Virginia Medicaid program as "a poorly run, inefficient bureaucracy with anachronistic fee schedules, punitive audit policies, and unnecessarily complex, often obscure, regulations." The program has been ranked 48th out of the 50 states in terms of delivering health care, the resolution continued, and is being sued by the American Hospital Association for inadequate reimbursement. The resolution concluded by calling for "a complete and thorough investigation of the Medicaid system in Virginia" by the General Assembly.

Dr. Krueger pointed out to the delegates that a study of the Medicaid program is in progress and is being monitored by the Society's State Legislative Committee, and to that committee **the resolution should be referred.** The House adopted the recommendation so to refer.

Consent Calendar

Expressing its "sincere thanks and appreciation for the Auxiliary's invaluable assistance and support," the Reference Committee recommended for filing the Report of the Auxiliary Advisory.

The Committee recommended for filing the Report of the Executive Vice President and expressed its "sincere appreciation to Mr. Moore and the staff for their continued service."

With the Reference Committee's commendation for his "many years of dedicated service," the Remarks of Speaker William H. Barney were recommended for filing.

Also recommended for filing by Reference Committee Three were all or parts of the Reports of the Alternative Delivery Systems and Emergency Medicine Committees; the Reports of the AMA Delegates and the Editorial Board; and six items from the Report of Council relating to the Scholarship, Finance, and Physicians' Health/Effectiveness Committees, the annual meeting format/ site, and MSV/AMA unification.

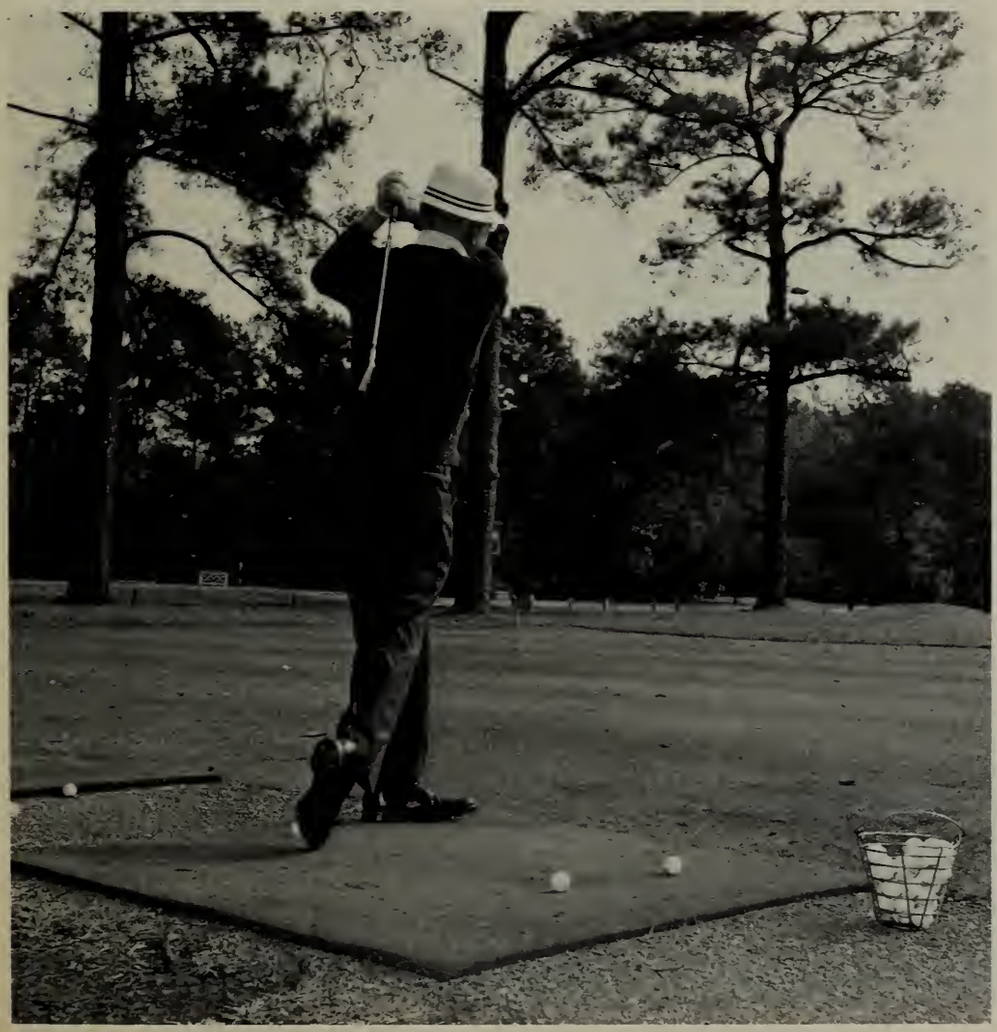
Dr. Clifford A. Nottingham, Roanoke, at the scientific exhibit on the paleopathology of pre-Columbian mummies presented by Dr. Enrique Berszten et al, Richmond

Recommended for adoption by the Committee were **the Reports of the Bylaws, Membership, and Physicians' Health and Effectiveness Committees,** and these two resolutions:

1) Resolution AA on Quality of Care Denials, introduced by Dr. Ira J. Green, which read, RESOLVED, **that The Medical Society of Virginia support the Medical Society of Virginia Review Organization in its efforts to exclude the provisions regarding notification of beneficiaries of quality of care payment denial decisions from the Social Security Act and related regulations.**

2) Resolution H on Health Insurance for Motorcyclists, introduced by the Norfolk Academy of Medicine, which stated, RESOLVED, **that The Medical Society of Virginia encourage the General Assembly of Virginia to enact legislation to require that all persons licensed by the Commonwealth of Virginia to ride in two-wheeled vehicles demonstrate a level of health care insurance sufficient to cover accidental vehicular injuries.**

Dr. Michael W. Russell rose to voice his opinion that it would be appropriate to refer the second resolution to the Highway Safety Committee and he so moved to make that referral. The House agreed and **voted to refer.** ■



Dr. John A. Martin, Roanoke, on the driving tee

VIRGINIA MEDICAL

EDITORIAL

President Hulvey

It is a genuine privilege to introduce the President of The Medical Society of Virginia for 1988–1989, Dr. J. Thomas Hulvey, whose distinguished service to the practice of medicine, to the Society and to his community eminently equip him to foster the continued development of The Medical Society of Virginia in this rapidly evolving time.

Tom Hulvey was born in Staunton, Virginia, on November 15, 1935. Following graduation in 1962 from the University of Virginia School of Medicine, Dr. Hulvey completed his surgical internship at The University of Florida. He then saw duty as a medical officer in the United States Navy from 1963-1965. Returning to the University of Virginia, he completed his residency in orthopedics and entered private practice in Abingdon, Virginia, in 1969.

He is a diplomate of the American Board of Orthopaedic Surgery and a fellow of the American Academy of Orthopaedic Surgeons and the American College of Surgeons. Tom Hulvey is a member of the Washington County Medical Society, Southwestern Virginia Medical Society, American Medical Association, Southern Medical Association, Virginia Orthopaedic Society, Orthopaedic Society for Sports Medicine, Eastern Orthopaedic Association, Southern Orthopaedic Association, and the Sports Medicine Committees of The Medical Society of Virginia and the Virginia Orthopaedic Society.

A former President of both the Washington County Medical Society and the Southwestern Virginia Medical Society, Tom Hulvey served in the House of Delegates for The Medical Society of Virginia and was chairman of the Membership Committee and the Vanguard Committee. As 9th District councilor, he served from 1979 to 1985. He was elected as an alternate MSV delegate to the American Medical Association. In 1985, he was elected Second Vice President and the following year, First Vice President. In 1987, he became President Elect.

President Hulvey

For the University of Virginia and its School of Medicine, he has been vice chairman and chairman of the Medical Alumni Advisory Committee. He is a consultant in hand surgery and sports medicine and a member of the University of Virginia Student Aid Foundation.

Dr. Hulvey is a staff orthopaedic surgeon and member of the board of trustees, Johnston Memorial Hospi-

tal, Abingdon, Virginia; orthopaedic consultant, Virginia Bureau of Crippled Children; consulting orthopaedic surgeon, Southwestern State Hospital, Marion, Virginia; and clinical assistant professor, Department of Orthopedic Surgery, Medical College of Virginia, Richmond.

In Abingdon, he has served for many years as a member of the Barter Foundation, which operates the state theater of Virginia. He has been a member of the advisory board of Central Fidelity Bank and the Washington County School Board and actively worked in sports medicine in Southwest Virginia with Emory and Henry athletic teams, as well as area high school teams and Little League programs.

It gives me great personal satisfaction that he was presented the Second Annual Award given by the Virginia High School Coaches Association to the individual who has given the most to the medical care of the high school athletes.

Dr. Hulvey married Elizabeth Lewis Kelsey, a native of Blacksburg, Virginia. They have two daughters and a son.

Tom Hulvey will diagnose and treat the problems of The Medical Society of Virginia in the same decisive, wise and honest way that he handles his patients—practical in his approach, but fair to all in recognition of their just and proper needs.

His ability to cut through the extraneous material to expose the vital crux of any issue is clearly apparent to all in contact with him.

Dr. Hulvey has the ability to accomplish any task imparted to this office. He will perform his duties with vigor and a steadfast and stalwart manner. Please join me in wishing him well.

FRANK C. MCCUE III, MD

University of Virginia Health Sciences Center
Charlottesville, Virginia 22908

MSV Progress

SINCE the unfortunate division of opinion over the American Medical Association/Medical Society of Virginia unification, with the resultant loss of MSV members, the Society has buckled down and continued to go forward. But progress has not been easy.

During the past year, the Society has been fortunate in having as president Dr. Glenn Updike, an industrious and innovative leader. His good judgement and thoughtful evaluation of complex problems have served the Society well. We are grateful for his leadership.

Now, in Dr. J. Thomas Hulvey, the Society has another outstanding leader and prospects are bright for a continuation of this progress. But we must actively support Dr. Hulvey and the other MSV leaders. Medicine in Virginia needs MSV support; non-members certainly don't supply it.

E.L.K., JR.

Forgiving

MOST patients are far more forgiving and tolerant of our errors and foibles than we think. Over the years far more patients have overlooked my oversights than have nitpicked and found fault when I was faultless. Even when I have erred, many a patient has made excuses for me.

Yes, rapport with the patient is almost everything. If the patient likes you, trusts you, and knows that you are sincerely interested in the problem, even major gaffes are overlooked.

I am in the habit of telling patients entering my examining lane to have a seat in the big chair so that they will sit in the examination chair rather than in the chairs for relatives. Several years ago I called a lady's name, and when she arose, I noticed she was very obese, with most of her excess weight in her hips and thighs. Her shape was so unusual as to be almost grotesque. With my mind wandering over thoughts about her large hips perhaps being the result of some metabolic or endocrine problem, I told her, "Please have a big seat in the chair."

She looked at me, and I mortifiedly returned her gaze and gasped, "I don't believe that I just heard what I just heard come out of my mouth." I smiled my best smile, and smitten with my obvious charm and sincerity she laughed. I laughed. We laughed and chuckled and made friends.

I finished her examination, explained her problem, and gave her a prescription. She left with the firm conviction that my medication would help because we had rapport. I had charmed her in spite of my initial Freudian slip. Another instance of honesty, charm and sincerity winning over a patient who could have been very hostile. Yes, I was proud of how I had handled my error.

I never saw her again.

HENRY S. CAMPELL, MD

FROM THE ROSTRUM

The President Addresses Some Chief Concerns

Glenn B. Updike, Jr., MD, President 1987-1988,
The Medical Society of Virginia

When I assumed office as your President one year ago, I touched in my remarks on some of the plans and objectives I believed needed our attention in the forthcoming year. You will not be surprised to learn that many of our problems remain with us, nor will you be further surprised to learn that some other little challenges arose during the course of the year.

At this time I will address the chief concerns of our members as judged by our mail and by reactions I have encountered in speaking to component societies. The actual work of the Society is covered in the committee reports and in the report of Council. I commend them to you for a complete report on Society activities.

In the spring we began to receive complaints from members about Blue Cross/Blue Shield charges for electronic claims submission and the introduction of a new paper claim form. As directed by Council, we engaged a data processing consultant to advise us in an approach to these problems. We have met with BC/BS top management on a number of occasions as reported. The net result of our conversations is that BC/BS stands fast on its business decision to charge for electronic claims submission but did agree to postpone charging until 1 November. They had previously indicated that HCFA 1500 forms would receive the same processing attention as in the past for paper claims. We urge members to keep documented records of claims difficulties and report them to Medical Society of Virginia headquarters as well as to BC/BS, so that the situation can be properly monitored.

Presented before the House of Delegates at the annual meeting of The Medical Society of Virginia on November 5, 1988, at the Williamsburg Conference Center.

Membership loss has remained a problem. The decrease creates fiscal problems, but in my judgment loss of members per se is more significant. I believe that The Medical Society of Virginia should be just that, a society composed of most if not all of the physicians in the commonwealth.

For this reason, it is essential for the welfare of our Society that we have under constant review our major policy decisions and their ongoing effect. The record shows that following our decision to unify in 1985, we lost approximately 1400 members and the American Medical Association gained 1600 new members in Virginia. In addressing properly my responsibilities as your President, I therefore felt concern over the AMA dues increases recommended by the AMA Board of Trustees for 1989 and 1990. That is, I did not want to wind up "head flea on a dead dog." I am aware that each of us often fritters away $23.00 without a thought. I am also aware that we and our professional brethren have used less weighty straws than this to break the back of a camel received with only marginal enthusiasm by some.

Therefore, on behalf of the Virginia delegation at the annual AMA meeting in Chicago in June, I proposed at the Unified Societies Advisory Committee meeting and at the appropriate reference committee that the six unified states be granted an exemption from the dues increase. The reference committee did not recommend nor did the House of Delegates grant the exemption.

I have given careful thought to the possibility of recommending an equal decrease in MSV dues to offset this increase, but in view of our ongoing expenses, particularly in the legislative and lobbying field, I cannot in good fiscal conscience recommend a decrease.

My concern, of course, is that of further membership loss. Council addressed this problem in September through the following resolution: " . . . that the President appoint an ad hoc committee to look into the problems associated with unification and deunification and to conduct a survey including groups they deem fit and report to Council with their findings at the earliest possible time."

I have appointed this committee, chaired by Dr. Jim Patterson, who will be membership chairman next year. We have met with membership representatives from the AMA, and they are preparing surveys to be directed to members we have lost and to other physicians as well who are not MSV/AMA members. These are to be submitted to us for review. Also plans for a membership recruitment effort have been submitted and are being evaluated. The AMA proposed a "bonus recruitment" plan directed at the employment of physicians no longer in practice as "recruiters." I believe that monetary rewards should more appropriately accrue to the Society than to individuals. I proposed that they present a plan that would accomplish this objective and if done, I would appeal to the leadership—officers, councilors, vice councilors, MSV delegates and alternates and AMA delegates and alternates—to accept the challenge in a true peer-to-peer effort in recruitment. The AMA has responded with a plan with greater monetary incentives and with membership goals that deserve intense effort on our part. I therefore call on all of our leadership to join in this effort and accept specific assignments.

To summarize my appraisal of the present unification/deunification situation: I do not consider it an issue at this annual meeting, constitutionally or otherwise. Council has directed an approach that we are following. With information from the surveys and with membership recruitment results in hand, we can make informed decisions. I believe it to be less than reasonable not to keep our minds open on this question. It is essential that our conclusions be reached with the best interests of The Medical Society of Virginia in mind. This, of course, is the primary responsibility with which we are charged. We must maintain the strength of our convictions on behalf of medicine in Virginia. We also must fortify the strength of these convictions with strength in numbers, particularly in our dealings with the legislature.

There is no doubt that we have lost members because of the $250 assessment levied by the General Assembly as part of the financing of the Injured Infant Act. Diligent efforts have been made to inform all physicians about the act, its potential benefits and the necessity for the assessment. Judging from certain responses, we have not been totally successful in our objective. However, we now have prepared amendments to the act to be proposed to the General Assembly in January. If passed, the assessment would be curtailed, though it is not likely that it would become effective in 1989. I do believe that if support of the proposal is accompanied by only a portion of the vigor, imaginative eloquence and energy we have seen in opposition to the assessment, it cannot help but pass. Please be prepared to mount an intense legislative effort in support of this proposal.

VaMPAC and The Medical Society of Virginia can have more effective legislative impact with closer and broader cooperation in evaluating legislators and their positions. The Legislative Committee has established a grass roots legislative task force. In conjunction with this, I propose that Council take steps to ensure that the VaMPAC directors receive input from councilors, vice councilors, and the legislative committee member from each district, as well as our lobbyists, before making any decisions on candidate support. We will also have information available from Virginia CARE, a service that provides records of each legislator's vote in committee and on the floor. I ask that the House adopt and approve this proposal.

The shortage of bedside care for patients was addressed by the AMA through the concept of pilot programs to train registered care technicians to help fill the gap. Your delegation to the AMA supported this concept. It may not be the final solution to the problem of bedside care, but it has brought forth a great deal of reaction which I hope will translate into positive cooperation among all concerned with patient care. We have reactivated the Joint Care Committee to represent us in this field.

We have continued to work toward higher levels of physician reimbursement, particularly in the field of primary care. Some success has been obtained, but funding is still not adequate. The recently released Resource Based Relative Value Study will offer support for readjustments in the "cognitive" fields. The Society will be represented at the AMA/RVS conference in Chicago.

The Auxiliary, under the leadership of its energetic and peripatetic President, Carole Lougheed, has continued with its indispensable activities in medicine's behalf. Again, quite simply, we could not do without them.

Most organization work is done through its committees. I particularly wish to commend Ken Tuck of the Legislative Committee, Ron Davis of the Professional Liability Committee, Jim Ghaphery of the Injured Infant Task Force, Hayden Hollingsworth of the Membership Committee and Ira Godwin of the Insurance Committee. The Executive Committee and Council have labored willingly and faithfully on the Society's behalf. There are many others who also deserve the thanks of the Society: these will become apparent as you study the committee reports.

There are many to whom I and the Society owe thanks. I do not believe that anyone who has not occupied the position I have this year can fully appreciate the role that Jim Moore plays in our organization.

The term "dedicated" is used often and rather freely, but I know firsthand that Jim's dedication and devotion to the Society are total. The joys of the presidency do not come unaccompanied by certain moments of challenge, if not despair, and it has been most reassuring to have the Executive Vice President to smooth out and insulate one from some of the bumps along the way. I submit that Jim Moore is a worthy successor to his honored mentor, Bob Howard.

The Society's staff members "behind the scenes" have performed smoothly and efficiently. I have been well supported by my own office staff. I am grateful to my colleagues, Drs. Richard Patterson, William Broach, and DeWitt Ellis, for their generous coverage for me when I've been on the road.

Most important to me personally, I extend to my wife, Betty, my everlasting thanks for the added measure of patience and support . . . above and beyond . . . that she has given me in the past year.

Now, permit me a bit of a homily as I conclude. Medicine as the profession we know can survive only if we adhere to the basic traditions sacred to our predecessors. Concern and caring devotion in each of the two million to four million patient visits a day in America must be maintained to ensure patient trust and confidence. To do this, we must develop our skills though continuing medical education, adopt firm quality assurance procedures, and through our own peer review process assure that our profession is kept free of those who are incompetent or unfit. Unless we do this we can not properly claim that the health care system of which we are a part is the best in the world.

On the other hand, we are beset by forces that would dictate how health care will be delivered. We must not let the almighty bottom line, corporate or governmental, create guidelines that impair quality of care. Rationing of health care is now a reality: who will have the liver transplant? how many coronary bypasses can we afford? how many carotid endarterectomies equal how many lens implants? A prudent concern for fiscal reality is necessary but the basic decisions must remain in physicians' hands. Unfortunately, the doctor no longer sits alone in the consultation room with the patient. Somewhere nearby, as "close as your telephone", sits a "patient treatment management coordinator" or some such, armed with a recipe book and a computer screen ready to tell you that you must do with the patient and how long you may take doing it.

We must make our influence felt. From a position firmly based on public trust and confidence, we must approach government through organized medicine: our component societies at the local level, The Medical Society of Virginia at the state level, and AMA at the national level. Just as important we must constantly reach our legislators as individuals. Success is not guaranteed but we shall surely lose by default if we do not persevere in all of the above.

If you don't believe me, let me refer to an authority, Chairman Dan Rostenkowski of the House Ways and Means committee. When asked at the AMA National Leadership Conference what doctors could do to be heard he said (and I paraphrase), "Doctor, over here in Washington we read the *Washington Post* and the *New York Times* and we believe what we read so if you want to be heard you had better get hold of your representatives and senators and tell them what you think." Therefore, if we do provide the best health care in the world we must be prepared to work for its survival; otherwise it will be merely a thing of the past.

As I have said, I have many to whom I am grateful for support, aid and comfort this past year. I happen to believe that for a Virginia physician, particularly one born a Virginian, there is no higher honor than the privilege of serving as President of The Medical Society of Virginia. Therefore, my deepest thanks are extended to you, my friends and colleagues, who gave me this opportunity for service in our beloved Commonwealth. For this, I will be always and truly grateful.

A TRIBUTE TO
SANFORD WARSHAUER, M.D.
(1935 - 1988)

We have suffered a deep loss and mourn the untimely death of a true leader of Alexandria Hospital and our Medical Staff. He served as a guiding force at the Hospital, particularly in the development of the comprehensive family-centered maternity services we offer today. He infused a spirit of compassion and professionalism that will be tremendously missed. But, in his absence, we will carry on his tradition of excellence.

We are grateful for having had the opportunity to work with someone as caring and progressive as Dr. Warshauer, someone who always pushed us to be the best we could be. He truly made a difference at Alexandria Hospital.

▲ ALEXANDRIA HOSPITAL

OBITUARY

A. Epes Harris, Jr., MD
1925-1988

Dr. Andrew Epes Harris, Jr., for 36 years a family physician in Blackstone, Virginia, died unexpectedly on November 13, 1988, in Winston-Salem, North Carolina. He was 63 years old. Dr. Harris had gone to North Carolina to see his second grandson, born November 9 to his daughter, Amanda, and her husband, George Woolen.

Only six weeks before his death, in a ceremony at the State Capitol in Richmond, Dr. Harris had been named a Virginia Cultural Laureate for his pivotal role in the establishment, in 1970, of Virginia's family practice residency program, which encourages young physicians to serve rural areas. He founded the Blackstone Family Practice Center with his brother, Dr. James Selden Harris, who survives him, and Dr. Stuart Bruce White, and it became the rural arm of the Medical College of Virginia's family practice department, with all three physicians serving on the MCV faculty.

A. Epes Harris, MD
1925-1988

Deeply rooted in Virginia, Dr. Harris could trace his ancestry to an Englishman who came to Virginia in 1611, Thomas Harris, and to Francis Epes, who settled in Virginia in 1623. Plantations figure in the family's history, among them "Norwood" and "Millwood" in Powhatan County and "Appomattox Manor" (now called "Epes Manor") near Hopewell. Ulysses S. Grant made the latter his headquarters during the seige of Richmond, and the estate is now a federal historical park. Epes Harris lived in Blackstone in a house his grandfather built; his bedroom was the room in which he was born. He had roots in Virginia medicine, too: His great-grandfather, Dr. William Jordan Harris, was a member of the first Virginia State Board of Medical Examiners, created in 1884.

Educated at Hampden-Sydney College and the Medical College of Virginia (M-51), where he also performed his residency, Epes Harris from early on in his practice was committed to organized medicine. He had been president of the Southside Medical Society and a delegate to Medical Society of Virginia meetings, and he had also led as president the Virginia Academy of Family Practice. For the American Academy of Family Physicians, he was a longtime delegate to the Congress of Delegates. His contribution to The Medical Society of Virginia centered chiefly on the Virginia Medical Political Action Committee, for he was convinced that the profession of medicine should make itself heard in legislative chambers, and he was a veteran VaMPAC board member. Clinical superiority was his, too; he was a charter diplomate of the American Board of Family Physicians and a fellow of the American Academy of Family Physicians. For these and many more professional organizations he had served in numerous advisory capacities and on countless boards and committees.

At his death he was chairman elect of the Medical Division, Medical College of Virginia Alumni Association. In his native community, the Blackstone Chamber of Commerce saluted him in 1976 with its service award, he had been president of the Blackstone Rotary Club, and he was an elder of the Blackstone Presbyterian Church.

An editorial in the Blackstone Courier-Record said this of him in part:

"When it came to serving his fellow man, Epes Harris never ran out of energy. Through his efforts Blackstone became the site of the first Family Practice Center in Virginia. Dozens of physicians have been trained here in how best to provide family health care. He helped establish other such centers around the nation. The world is a better place because Epes Harris lived and served . . .

"Little Travis Edward never got to know his grandfather, but as he grows up he will hear much about the man we all loved and so greatly mourn."

Dr. Harris' wife, Arline Raney Harris, also survives him, as do another daughter, Elizabeth Selden Harris, Newport News; a son, Andrew Epes Harris III, Mobile, Alabama; and two sisters, Lunette Harris Beale and Katherine Harris Coleburn, both of Blackstone.

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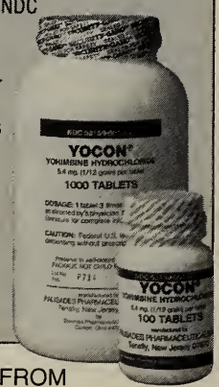

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olume 116 February 1989 Number 2

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LETTERS

"Light at end of smoke-filled tunnel": Va Med's text on smoking in hospitals

After reading the November 1988 issue of VIRGINIA MEDICAL, I saw light at the end of the smoke-filled tunnel. I am very encouraged by the articles on smoking in hospitals[1,2] and the letter of Delegate George W. Grayson.[3]

About a year ago, I started pushing a local hospital to institute a restrictive smoking policy. Fortunately, the administration was very receptive and a smoking committee was formed. It was important to have both smokers and nonsmokers represented on the committee. After a long deliberation and research, we have finally come up with a smoking policy. This will severely restrict visitors and staff and will be gradually phased in. Public buildings of this sort were not built with smoking policies in mind.

One of our obstacles was and still is how to tell the handful of physicians they cannot smoke in the physicians' lounges, dressing rooms, and dining areas. Some of them are hostile towards this smoking policy, and we all understand change does cause some uneasiness. On the other hand, many smokers understand that smoking is an environmental pollutant, and they have been very cooperative.

The global issue of smoking in our society is a difficult problem. I hope that physicians will be at the forefront of helping our society achieve a smokeless state at some point in the future. The economics of smoking and health care will certainly help change our ways. It will be extremely expensive for our society to continue to provide health care for those individuals who have been harmed by their long history of smoking.

Once again my congratulations. Keep up the good work.

Isaac Koziol, MD

5855 Bremo Road
Richmond VA 23226

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2. Davy N. Witness: "We could watch our patients and smoke a couple of cigarettes." Va Med 1988;115:528–529
3. Grayson GW. Delegate Grayson to seek no-smoking areas in hospitals (letter). Va Med 1988;115:508

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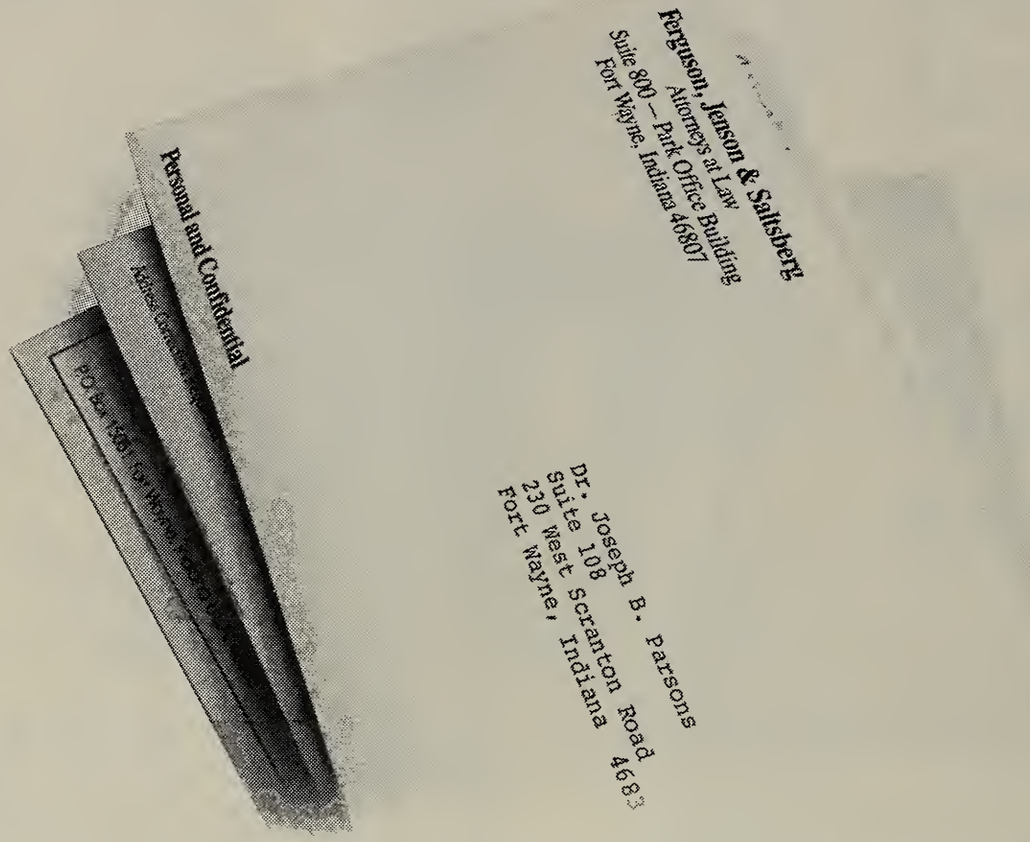

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FROM THE CAPITOL

Insuring a Healthy Medical Liability Insurance System

Mary Sue Terry, Attorney General of Virginia

MEDICAL malpractice insurance is as important to a smoothly functioning health care system as anesthesia in a surgical suite: you just can't operate without it.

I am concerned that persistent problems with medical malpractice insurance might result in Virginia's citizens being denied adequate health care. The tort reparations system for compensating victims of medical malpractice is not simply a financial mechanism. It affects victims of malpractice, doctors and hospitals, consumers, lawyers, insurers, businesses and government.

While these groups may have goals that often conflict, it is generally agreed that a good tort system should encourage quality medical care; provide fair and humane treatment of victims; encourage economic efficiency; and provide for predictability of victims' compensation and insurers' costs.

No simple approach can accomplish all these goals. Our response in Virginia has been multi-fold, including close regulatory scrutiny, limited tort reform, establishment of the Virginia Birth-Related Neurological Injury Compensation Program, and authorization of a Joint Underwriting Association for medical malpractice insurance. Despite these efforts, there are still imbalances in the tort system in Virginia.

We can get some idea of the complexity and subtlety of the medical malpractice issue by looking at the situation in our state's hospitals that have associated medical schools, and that treat many of the Commonwealth's indigent patients.

Medical faculty members often have private practices that complement their work as state employees. The State pays for their medical malpractice insurance in their capacity as employees of the Commonwealth, but they are on their own in purchasing malpractice insurance for their private practice associated with the institution. Some doctors report that their malpractice insurance premiums take as much as half of their state salary.

If this insurance situation is not resolved, our medical schools may eventually be unable to recruit faculty members—especially in "high risk" specialties. And the people who will be hurt most are Virginia's neediest citizens. Thus, we are faced here with an important issue of public policy. We need to find an approach that will keep in balance the needs of the doctors, the state institutions, and the patients they serve.

The search for solutions to the problems with medical malpractice insurance is complicated by the fact that medical malpractice insurance is "a land of many contrasts." What appears to be a solution in one place may not help—and, indeed, may hurt—in another place. Our first challenge, then, is to develop a road map of medical malpractice insurance, to see where we have come from, where we are today, and what routes we might take to get to where we want to go. Here are some of the approaches that have been tried or proposed for Virginia.

- Under insurance regulatory reforms drafted by my Office and unanimously adopted by the General Assembly in 1987, the State Corporation Commission annually reviews Virginia's commercial liability insurance market and designates those lines it has reason to believe are potentially noncompetitive.

In November 1987 the SCC designated medical malpractice insurance as a potentially noncompetitive line of insurance. Last July the Commission found that it is in fact noncompetitive, subjecting rate requests to prior review.

Since 1987 my Office has made a commitment to monitor requests by insurers for rate increases. For example, when St. Paul asked for a 29.5% medical malpractice rate increase in 1988 (after receiving a 15% increase in 1987), we hired an insurance consultant and actuary to review that rate request.

Regulatory scrutiny can help keep medical malpractice insurance rates from becoming excessive within

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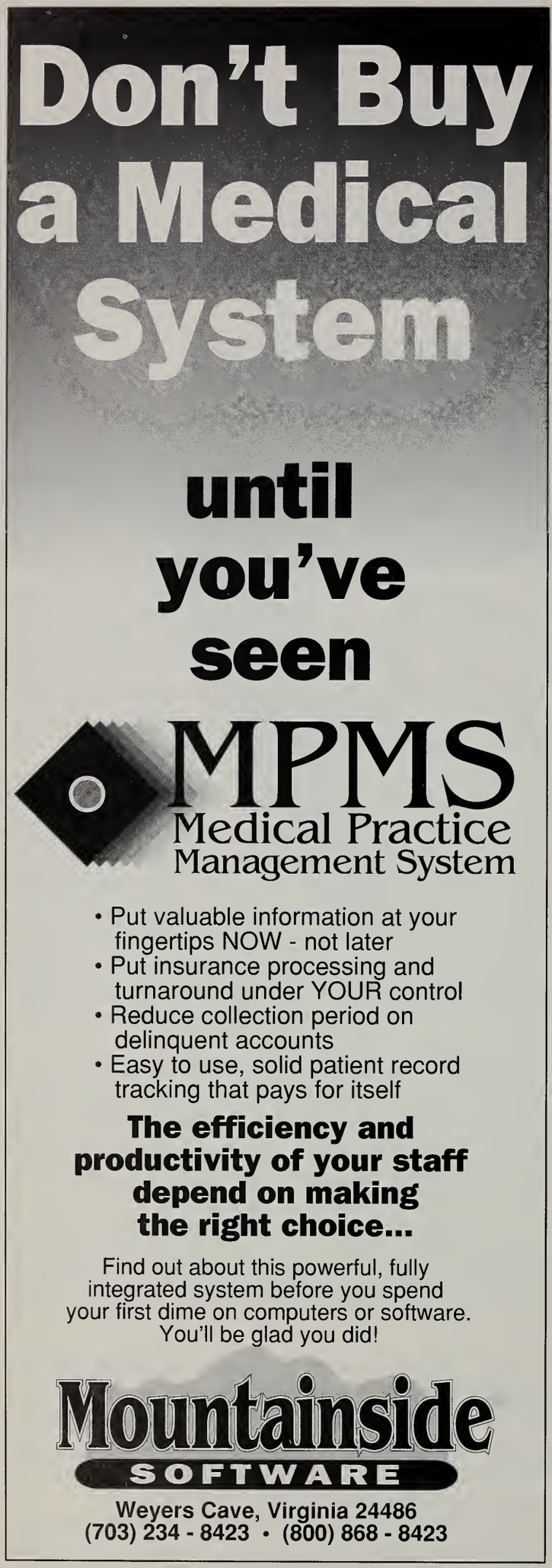

the meaning of the Code of Virginia, but it does little to address problems of unavailability. And clearly, regulatory effectiveness is enhanced when the medical profession becomes its own best advocate, as when The Medical Society of Virginia hires an actuary to evaluate proposed rate increases and provides input to the regulators.

- The Joint Underwriting Association deals with the availability problem but does not help much with affordability. The JUA's premiums are usually higher than ordinary-risk premiums, and the size of the JUA's risk-sharing pool is limited, although that has improved somewhat as more doctors have joined the JUA.
- The Birth-Related Neurological Injury Compensation Program removes a category of serious injuries from the tort system, but since no claims have been filed thus far, the effectiveness of the fund in compensating victims has not yet been tested, and no significant reductions in medical malpractice insurance rates have resulted to date.
- While at first glance shared risk pools, or risk retention groups, would appear to solve both affordability and availability problems, there are practical concerns that make this apparently simple solution difficult to achieve.

We in the Office of the Attorney General are concerned about the health of medical malpractice insurance in Virginia. We know that good insurance principles and sound underwriting practices are central to any kind of risk management strategy, whether by a commercial insurer or through some pooling arrangement. We recognize that the inventory of an insurance company—or a shared risk pool—consists primarily of the money it holds in trust to meet obligations incurred under the policy contract. The insurance product is not fully delivered until all claims are paid and all policies have expired. If an insurance company fails, its customers and many other people will be hurt. We don't want that to happen in Virginia, any more than we want Virginia's insurance consumers to pay more than they should for the protection they need.

We need to hear from Virginia's physicians, so that we have a clear picture of the medical malpractice insurance situation in Virginia and can decide how best to allocate our resources to meet the many needs of our citizens. I encourage Medical Society of Virginia members to let my office know of any specific problems and concerns.

Our goal is an insurance environment in which individuals, businesses and professionals can obtain the protection they need at a price they can afford; in which our citizens can enjoy the benefits of quality health care and protection for injured workers; in which businesses and entrepreneurs can take the necessary risks to develop and market products; and ultimately, in which our citizens can achieve their fullest potential. ■

MEDIBYTES

NEWS FROM VA MED'S COMPUTER ROOM

MARY SUE IN THE CARRIERS' DEN

Elsewhere in this issue Virginia's Attorney General, Mary Sue Terry, asks Virginia physicians to write to her. She wants to know your experienced problems with the medical liability insurance situation and your concerns about it. Ms. Terry has been challenging the insurance industry, a formidable adversary, and seems to be feeling the need for help. That's not surprising, since a legislative subcommittee failed to support her key initiative, a recommendation to restrict the ability of insurance companies to use certain data collected by rating bureaus. The insurance industry's lobbyist told the subcommittee the Attorney General's proposal would lead to higher costs for many small companies and thus to higher rates for consumers. The subcommittee came down 9-1 on the carriers' side; the lone supporting vote came from Del. Thomas W. Moss, Jr., the subcommittee's chairman. Answer Ms. Terry's plea. Write! Her office is at 101 North Eighth Street, Richmond VA 23219.

STATE COURT'S RULING ON CAP TAKES COUNCIL SPOTLIGHT

News of the Virginia Supreme Court's decision upholding the constitutionality of the cap on medical liability awards dominated the meeting of The Medical Society of Virginia's Council on January 14 at headquarters. MSV President J. Thomas Hulvey conducted the meeting.

"It's a good decision, carefully written," observed counsel Allen C. Goolsby III, "and it is very important substantively and PR-wise, but the issue will not be over until the 4th Circuit Court case is decided." The case before the U.S. Court of Appeals, 4th Circuit, is an amicus curiae brief filed by Goolsby on the Society's behalf to test the legality of the cap. "We'll have a decision there in a couple of months," the attorney predicted. "If the decision is not favorable, we can go to the [U.S.] Supreme Court with it. I think there's a good chance the justices would be willing to hear it."

Virginia's law limiting medical liability awards to $750,000 was passed in 1976, and the state's trial lawyers have been trying to discredit it ever since. The action that brought the ruling by the state justices was

filed on behalf of a Virginia Beach mother of three who suffered brain damage in a 1980 operation and sued the hospital; she won her suit and the jury awarded her $2.75 million, but the judge applied the cap to the award. The judge's action, said the four-justice majority opinion, was in compliance with the law and should be affirmed.

Another state law, the much-discussed Birth-Related Neurological Injury Compensation Act, is under scrutiny by an MSV task force, and the group's chairman, Dr. James L. Ghaphery, had news for the councilors. The Williamson Institute for Health Studies at the Medical College of Virginia, he announced, has completed a pilot study of all infants born at the MCV Hospitals 1984-1987 in an effort to predict how many injured babies might qualify annually under the act's provisions as written. The study cost $10,000 and was underwritten by the Virginia Insurance Reciprocal and the Medical Protective Company.

Now, continued Dr. Ghaphery, the authors of that study want to move into a second phase, an analysis of the act's probable cost. Virginia's obstetricians have contributed $5,000 to fund this second phase, he reported, and he asked the councilors to allocate $3,500 to complete the funding. Promptly and unanimously, the councilors did so. (Scheduled for Virginia Medical's March issue are the data from the first-phase pilot study.)

Turning to a report on the Joint Underwriting Association, Dr. Ghaphery revealed that as of September 1 last, 315 physicians had joined the JUA. Of these, 56 are obstetricians, or 10% of the obs in Virginia. As of December 1988, 17 claims were pending, and four had been settled before trial.

The MSV Federal Legislative Committee, seeking support from Council for federal funding of biomedical research, got that support and more in a motion from Dr. Jeffrey W. Wilson. It not only advocated general support but asked for two specifics: first, that Dr. Hulvey discuss the issue when he speaks to Virginia's legislators at the Society's Congressional Luncheon May 3 on Capitol Hill, and second, that "correspondence to our appropriate congressmen be encouraged as directed by the committee." The councilors passed the motion.

At its meeting in Williamsburg last November, the Society's House of Delegates referred five measures to the Council for action (Va Med 1989;116:19-33:

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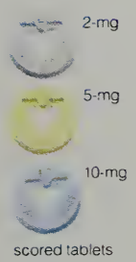

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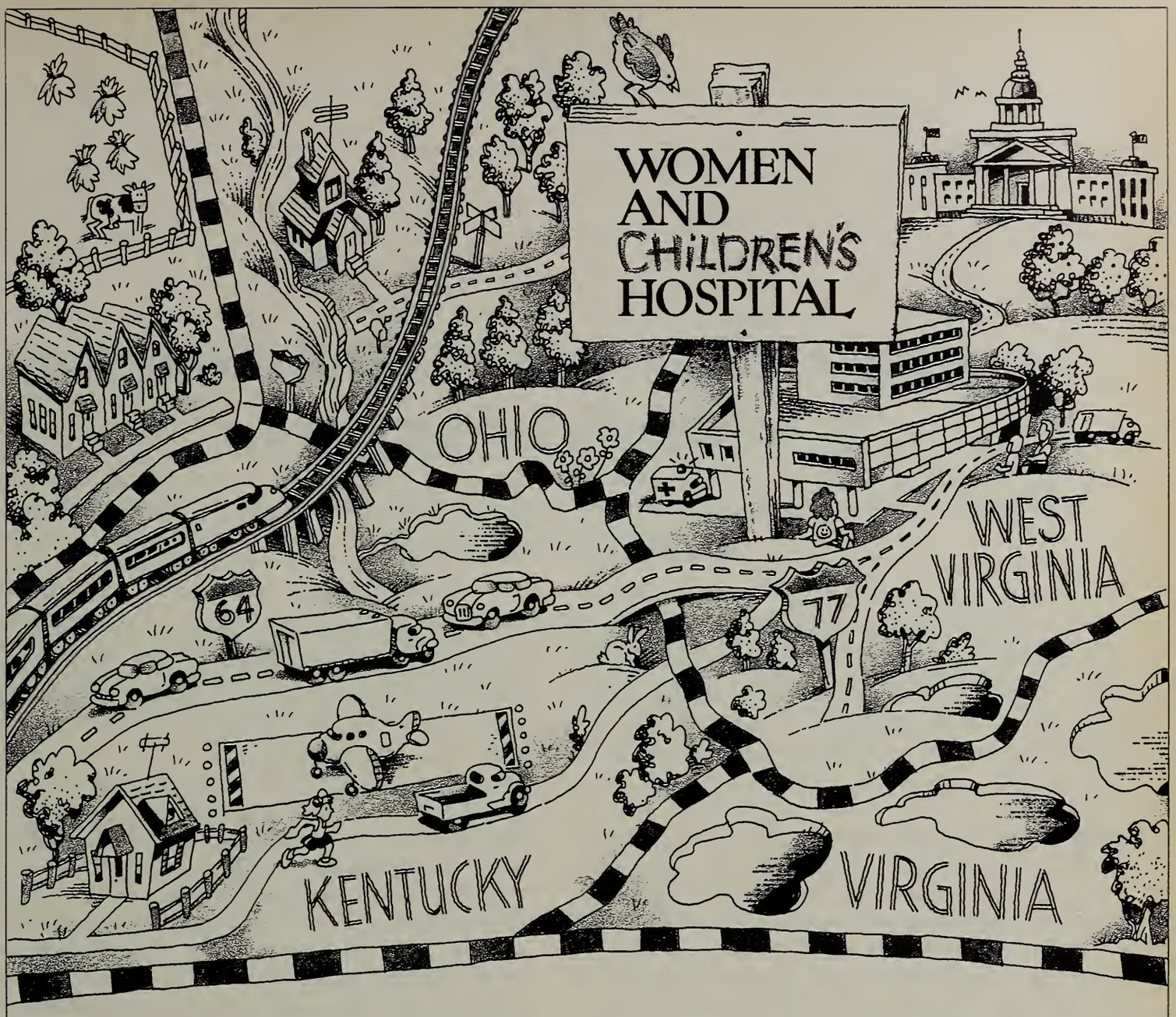
1. A resolution asking for state legislation requiring insurance carriers to cover screening mammography had given the reference committee pause because of the costs involved. The councilors were concerned about costs, too, their discussion revealed, yet they didn't want to say anything negative about this valuable procedure. Finally, Dr. Russell D. Evett framed, and the Council adopted, this position on the issue: "That The Medical Society of Virginia supports insurance coverage for appropriate screening mammography."

2. Conflicts of interest at the General Assembly proved too hot a potato for the councilors to handle, and they were unanimous that no action should be taken on the resolution that called for the imposition of voting strictures.

3. Another tough decision involved the resolution generated by a memorandum sent by state officials to retired state employees urging them to select for their health care physicians who participate in Medicare. "Just the beginning of restricting access to care," commented Dr. Stephen M. Ayres. "The state's trying to keep costs down," observed Health Commissioner C.M.G. Buttery, "and the choices are difficult." One of the councilors noted that action in postdate of the memo was as fruitless as shutting the barn door after the horse is gone. Fruitless or not, the Council shut the door by passing a motion offered by Dr. John A. Owen, Jr. The measure asked that letters be written to the proper officials asserting that it is "inappropriate for you to regulate the health care choices of your ex-employees solely on the basis of Medicare participation."

3. The recommendations from the MSV Review Organization Oversight Committee had been dealt with affirmatively, reported Dr. Eugene F. Poutasse, MSVRO medical director. Notably, the makeup of the Quality Assurance Committee will henceforth include three ad hoc members of the same specialty or type of practice as the physician under investigation. As for changes in the review of certain severity cases, Dr. Nelson G. Richards noted that these did not exactly paraphrase the Oversight Committee's requests, and they were sent back to the MSVRO board for minor alterations.

4. Also referred by the House was a recommendation of the Rural Health Committee that the Society continue to support efforts to equalize rural and urban payments by third parties to hospitals and physicians. On the motion of Dr. William H. Barney, the councilors voted to research what equalizing measures are being considered at the AMA and to check out any pertinencies in the Physicians Payment Review Commission report due March 1. --A.G.



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FEBRUARY 1989

Diagnostic Methods for Chlamydial Infections In a High-Risk Population

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An enzymeimmunoassay test performed well in comparison with cell culture in detecting chlamydial infections among 209 women at a public health clinic, detecting 73% of the infected patients. Clinical and epidemiological criteria alone identified only 52%. The authors consider the test an essential supplement to other criteria when looking for chlamydial infection in a high risk population.

One of the major causes of sexually transmitted disease in the United States, *Chlamydia trachomatis*,[1] can lead to a host of clinically important conditions, including mucopurulent cervicitis, urethritis, acute pelvic inflammatory disease, ectopic pregnancy and infertility in women; nongonococcal urethritis, proctitis and epididymitis in men; and inclusion conjunctivitis and pneumonia in infants, who acquire the infection passing through an infected birth canal.[1–4] Thus there is a need for early diagnosis and treatment of infected individuals, but one of the most disturbing aspects of chlamydial infections is their relatively asymptomatic nature in women.[5]

Until recently, diagnosis of chlamydial infections depended on recognition of clinical features or epidemiological suspicion and required confirmation using the time-consuming and expensive cell culture method. Although cell culture techniques have been modified and improved,[6,7] recent advances have made available several rapid detection systems.[8,9] Chlamydiazyme (Abbott Laboratories, North Chicago IL) is an enzymeimmunoassay (EIA) method which is offered by the state laboratory in Richmond for use among women attending the Health Department's sexually transmitted disease (STD) clinics. While treating patients attending the clinic at the Thomas Jefferson District Health Department in Charlottesville, we had the opportunity to compare the results obtained from the test offered by the state with 1) clinical diagnosis and 2) the tissue culture method performed in our laboratory at the University of Virginia.

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Materials and Methods

Patient Population. Clinical information was obtained from 290 consecutive women attending the Health Department's STD clinic in Charlottesville. Each patient was examined for *Chlamydia trachomatis* using the Chlamydiazyme test performed by the state laboratory and by cell culture.

Clinical Diagnosis. Patients who presented as the sexual partners of men with gonorrhea or nongonococcal urethritis or who manifested mucopurulent cervicitis (a purulent or mucopurulent cervical discharge) were treated at their first clinic visit with a regimen active against *Chlamydia*.[1] All other women were asked to call the clinic in seven days to obtain their test results and to return if treatment was indicated.

Specimen Collection. Prior to specimen collection,

excess cervical mucus was cleared away with a large cotton swab. Routine endocervical cultures for *Neisseria gonorrhoeae* were obtained, followed by duplicate swabs of the endocervical canal for the detection of *Chlamydia*. The Chlamydiazyme test kit (STD-EZE for women) included a cotton tipped swab with which the physician collected the endocervical specimen. The swab was snapped at midshaft and inserted into the cap so that its tip was held firmly inside a vial containing transport medium (0.2M sucrose-phosphate buffer with 10% fetal bovine serum). The vials were labeled, packed inside mailing tubes, and immediately refrigerated until they were transported to the state laboratory in Richmond. The turnaround time for results was approximately seven to ten days.

A second cotton swab obtained from the endocervical canal was used to inoculate a vial containing 2 ml of 2SP transport medium (0.2M sucrose-phosphate, 10 μg/ml gentamicin, and 25 μg/ml nystatin, pH 7.0). Within three hours of collection, these samples were frozen at −70°C until the isolation procedure for *Chlamydia* by cell culture could be performed.

Enzymeimmunoassay. STD-EZE tubes inoculated with cervical specimens for the Chlamydiazyme assay were held at 4°C and processed within 72 hours according to the instructions provided by the manufacturer.

Cell Culture. Inoculation and culture of confluent McCoy cell monolayers with cervical specimens were performed according to the procedure described by Bird and Forrester.[10] Chlamydial infection of the cells was facilitated by the addition of 1.0 mg/ml of cycloheximide to the growth medium. Each specimen was tested in triplicate. After a 48-72 hour incubation period at 35°C, two monolayers of each triplicate were fixed and stained with Microtrak *C trachomatis* culture confirmation reagent (Syva Co., Palo Alto CA), a fluorescein conjugated antibody specific for the outer membrane protein of *C trachomatis*. Positive controls, obtained from the Centers for Disease Control and negative controls of uninoculated transport media were stained with each run. Positive or negative cultures were determined by the presence or absence of typical, bright green inclusion bodies within individual McCoy cells. The third monolayer of an apparently negative specimen was passed to a fourth McCoy cell monolayer. After incubation for an additional 24-48 hours at 35°C, it was fixed and evaluated as above.

Results

Results of the two supplementary diagnostic methods are compared in Table 1. Using culture as the standard, the prevalence of infection was 10.3% (30/290). The sensitivity and specificity of the Chlamydiazyme method were 73.3% (22/30) and 94.6% (246/260) respectively. The predictive value was 61.1% (22/36) for a positive test and 96.8% (246/254) for a negative test. If, however, Chlamydiazyme is considered to be 100% specific, then *Chlamydia trachomatis* was identified by either Chlamydiazyme or cell culture in a total 44 of the 290 patients (15.2%). Primary cell culture identified 28 of the 44 cases (63.6%), and blind passage of negative cultures identified two additional cases for a total of 30 positive cases (68.2%). The Chlamydiazyme test identified 36 *Chlamydia* cases (81.8%). Eight cases were identified by cell culture alone, while 14 cases were positive by Chlamydiazyme alone (McNemar Chi square = 1.136, p = 0.29). The two cases identified as positive by cell culture only after blind passage were also positive by Chlamydiazyme.

Mucopurulent cervicitis or epidemiological data (i.e., contact to gonococcal or nongonococcal urethritis) were used as clinical indicators of chlamydial infection. Only 13 of the 30 (43%) infections diagnosed by culture were recognized on clinical or epidemiological grounds. Twenty-one of the 44 (47.7%) women with either test positive were treated initially on the basis of clinical evidence of infection or epidemiological risk. Among these 21 clinically recognized *Chlamydia* cases, six (28.6%) also had bacterial vaginosis, five (23.8%) had trichomoniasis, two (9.5%) had gonorrhea, and one (4.8%) had candidiasis.

The remaining 23 (52.3%) did not have mucopurulent cervicitis, although they were frequently symptomatic from other urogenital infections. Among these women, identified only by laboratory tests, ten (43.5%) had trichomoniasis, six (26.1%) had bacterial vaginosis, two (8.7%) each had candidiasis and urinary tract infections. Three were completely asymptomatic and had no other genital infection.

The prevalence of coexisting or multiple infections among the clinically recognized *Chlamydia* cases was 67% (14/21) compared to 87% (20/23) for the *Chlamydia* cases identified by laboratory tests alone (Chi square = 1.5, p = .2). Among the 14 women whose chlamydial infections were detected by the Chlamydiazyme test alone, 57.1% (8/14) were identified on the basis of clinical and epidemiological evidence, and 71.4% (10/14) of these women were coinfected. In comparison, 43.3% (13/30) of the women identified by cell culture had clinical or epidemiological evidence of chlamydial infection, and 76.7% (23/30) had coexisting infections.

Discussion

This study confirms other work showing that, when

Table 1. Comparison of the Results of Chlamydiazyme and Cell Culture for the Detection of *Chlamydia trachomatis* in 290 Women Attending a Sexually Transmitted Disease Clinic.

	Cell Culture		
Chlamydiazyme	Positive	Negative	Total
Positive	22	14	36
Negative	8	246	254
Total	30	260	290

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A new enzymeimmunoassay test for chlamydial infection suitable for performance in physicians' offices was released in October 1988 by Abbott Laboratories, Abbott Park, Illinois. Its name: TESTPACK® Chlamydial. Based on data from about 1400 women attending private gynecological practices (a low-risk population), the new test had a sensitivity of 90.0% and a specificity of 98.6% compared to Chalmydiazyme®. Personal experience with the test confirms its ease of performance. —M.F.R.

dealing with patients at high risk for chlamydial infection, it is essential to supplement clinical and epidemiological criteria for diagnosis with a laboratory test.[11] This was clearly evidenced by the 52.3% of our infected patients who were identified as having chlamydial infections only by the laboratory tests. In fact, two patients with clinically unrecognized chlamydial infection received appropriate treatment only because CDC guidelines call for the use of supplementary tetracycline HCl in the treatment of gonorrhea.[1]

Our evaluation of the Chlamydiazyme test in comparison to cell culture showed that the quicker EIA based method performed well in detecting the chlamydial infections of women attending an STD clinic. The 73.3% sensitivity and 94.6% specificity of the test for this particular sampling of women fell within the range of values determined by other investigators in similar studies[12–16] for which the sensitivities and specificities were 63.6 to 100% and 93.0 to 98.1%, respectively.

Many of our patients who were positive by EIA but negative by culture may have been truly infected. They did not differ from the culture-positive group in the frequency with which they had clinical or epidemiological evidence of chlamydial infection [8/14 (57.1%) vs 13/30 (43.3%), Chi square = .281, p = .6] nor did they differ in the prevalence of coexisting infections [10/14 (71.4%) vs. 23/30 (76.6%)].

The cell culture, dependent as it is on the presence of viable organisms in the specimen, may be falsely negative if organisms die in transit to the laboratory. Even though we processed specimens promptly, our cultures may have been subject to destruction of the McCoy cell monolayers by other organisms, including *Trichomonas vaginalis* and herpes simplex virus, which are prevalent in sexually active populations and which are unaffected by the antibiotics included in the collection and growth media. Indeed, one recent study suggests that the growth of *T vaginalis* may be enhanced by the presence of McCoy cells.[17] Interestingly enough, four of the cases of chlamydial infections detected by Chlamydiazyme but not by cell culture occurred in patients also infected with *T vaginalis*.

Chlamydiazyme, which is somewhat less sensitive and only slightly less specific than cell culture, is an obvious alternative for clinicians with limited access to laboratory facilities. The test itself involves detection of chlamydial antigen present in a specimen. It is not dependent on the viability of the infectious agent at the time of collection, nor is it dependent on the integrity of the cell culture system. Once inoculated, specimens can be refrigerated and then mailed within 72 hours to a central laboratory for testing, thus offering a relatively rapid, inexpensive and technically less demanding method for the detection of *Chlamydia trachomatis*. In a high-prevalence population such as that attending an STD clinic, the ability to detect otherwise unrecognized cases appears to outweigh the risk of false positive reactions (if they are indeed false positives) that may be seen with use of the EIA. The physician in private practice may see a somewhat lower risk population, but the ease of usage and the possible consequences of undetected infection make the EIA a highly useful test in this setting as well.

With EIA alone, 82% of those infected in this population would have been detected, and the infection rate would have been identified as 12.4% (36/290). This differs little from the 13.8% infection rate found by EIA alone in a group of 298 family planning patients tested in a Virginia clinic in 1986[18] or the 10.7% infection rate in a Wisconsin family planning clinic study.[19] For this reason, access to this type of testing should not be limited to STD clinic patients alone.

In 1985 the Virginia Division of Consolidated Laboratory Services first made the enzymeimmunoassay available to public health STD clinics and certain public health maternity and family planning patients. However, in the fall of 1986, the high rate of use and budgetary constraints forced a significant restriction on testing and, later, complete elimination of the test. In mid-1987 the test was once again made available but was restricted to asymptomatic women in STD clinics, leaving out high risk asymptomatic maternity patients and all family planning patients. Funds are expected in mid-1988 to broaden test availability to cover these public health clinic patients. Clearly the medical and economic consequences of untreated chlamydial infections in the medically indigent population served by public health clinics makes the provision of this test a sound policy for state government.

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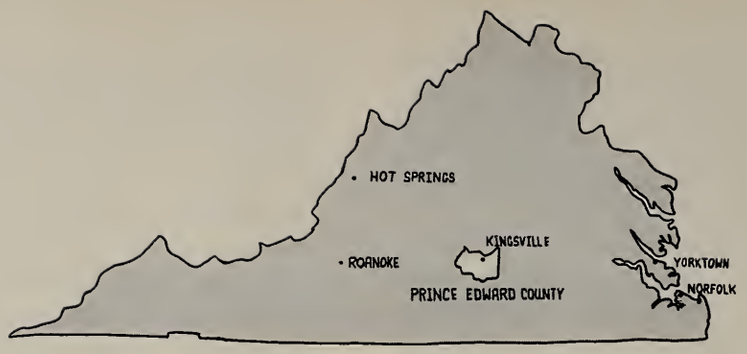


In Rural Virginia, World-Class Medicine: John Peter Mettauer, 1787–1878

John R. Kight, MD, *Virginia Beach, Virginia*

When he devised a method for repairing vesico-vaginal fistulas, the great Marion Sims took notice and did likewise. For his original work in congenital deformities he was called America's first plastic surgeon. "A genius of his time," summed up an article describing his innovations in ophthalmology. He was Peter Mettauer of Prince Edward Courthouse, Virginia.

In Prince Edward County, Mettauer is pronounced mə•täŕ. In France, where Peter Mettauer's father was born, it is pronounced Met•toweŕ.

ALTHOUGH the contributions of John Peter Mettauer to many areas of medicine have been extolled by leaders in the profession, he has never received the recognition he rightly deserves. For his accomplishments, his name should be ranked along with another great Virginian, Dr. Walter Reed.

Among those who have appreciated Dr. Mettauer's contributions to the extent they have found reason to publish facts about his life are some outstanding members of the academic and medical world. All have been especially qualified to do so, but none more than three of the first; Dr. George Ben Johnston, Dr. Joseph Eggleston, and Dr. M. Pierce Rucker. Dr. Johnston, who as chairman of the Department of Surgery at the Medical College of Virginia, where the school amphitheater bears his name, lived within the lifetime of Dr. Mettauer and had the advantage of being intimately aware of his prolific achievements. For his presidential address before the American Surgical Association in 1905, his theme was "A Sketch of John Peter Mettauer of Virginia."[1]

Twenty-five years after Dr. Johnston's presentation, Dr. Eggleston, then president of Hampden-Sydney College and for whom the school library is named, paid tribute by placing in the prestigious *William and Mary Quarterly* some known facts of the Mettauer family. This act by Dr. Eggleston for the benefit of future generations is extremely significant, because Dr. Eggleston spent nearly his entire life in the community where Dr. Mettauer had practiced medicine and established a reputation that extended into many states and abroad. Dr. Eggleston's family and the families of many of his associates had been patients of the doctor; from them he learned firsthand of Dr. Mettauer's remarkable accomplishments, his compassion, and his dedication to the profession.[2]

A decade later, Dr. Rucker, who as Editor of the VIRGINIA MEDICAL MONTHLY guided that journal into national prominence and whose extensive knowledge of the world medical literature distinguished him among his contemporaries, extolled Dr. Mettauer's accomplishments in a factual and scholarly article. In closing his biographical report, Dr. Rucker touched on the relationship between the work of Dr. Mettauer and that of Dr. J. Marion Sims, who erroneously is recog-

This text was abstracted from a lecture given by Dr. Kight before the Virginia Obstetrical and Gynecological Society on April 10, 1987, in Norfolk. Address correspondence to him at 4308 Sandy Bay drive, Virginia Beach VA 23455.

nized as being the first to have successfully repaired a vesico-vaginal fistula.[3]

JOHN Peter Mettauer was born on April 10, 1787, in rural Prince Edward County, Virginia.[4] All biographical reports state that John Peter's father, Francis Joseph Mettauer, a French surgeon born and reared in Soultzbach-les-Bains, Alsace, served with Lafayette in the Battle of Yorktown. Off and on over a period of 20 years, Adolf Michaelis, a descendant of the Mettauer family now living in Bonn, West Germany, and the author have researched military records on both sides of the Atlantic to determine in what capacity he served during the conflict. Many French military records were destroyed during the French Revolution, as were American records when buildings were burned in Washington in the war of 1812, and it is an established fact that Revolutionary War records are incomplete. It can be stated that no reason has ever been found to arouse doubt that Francis Joseph, the father, served with the French forces.[5,6]

It is well established that Mettauer père arrived in Kingsville, in Prince Edward County, Virginia, in 1781, soon after the Yorktown surrender, with a detachment of French troops proceeding south under orders of General Washington to reinforce the troops of Gen. Nathaniel Greene, since there was no assurance that all hostilities had ceased. En route some of the troops encamped at Charlotte Courthouse and others at nearby Kingsville. Those quartered at Kingsville were stricken by an epidemic of smallpox and were forced to remain in the area a prolonged period of time. Afterward, when the detachment departed, Dr. Joseph Mettauer (as he was known in this country) was persuaded by some of the prominent citizens to remain, and he thus became the first physician known to have practiced in Prince Edward.[7] In 1783 he became a naturalized citizen of the new nation, and within one year he purchased land, since divided by a highway between Farmville and old Prince Edward Courthouse, now Worsham. His first son, John Peter, was born on that parcel of land only six years after this country had won its independence and in the same year the Constitution of the United States was adopted.

On May 6, 1791, when John Peter was four years old, his father, Francis Joseph, married Jemima Gaulding, a widow from Henrico County, whose maiden name was Crump.[2] Most accounts imply that Jemima was the mother of Peter and his brother, also named Francis Joseph. Efforts to find conclusive evidence to support a belief that there was a previous marriage have resulted in only one positive piece of supportive evidence. William Lett Harris, President of The Medical Society of Virginia in 1926, tells us, ". . . his father built a Methodist church just across the road from the old home site, as a memorial to his wife. . . ."[8] This memorial, if it did exist, was not to Jemima; she was ejected from the home soon after the marriage and for a decade Francis Joseph tried to petition the General Assembly for annulment of the marriage. A deed recorded in Prince Edward Courthouse in 1813 confirms that Jemima outlived her estranged husband.

Little is known of Peter Mettauer's early life. Even his birth date has been questioned.[2] His early education was obtained at the nearby Prince Edward Academy. In 1804 he matriculated at the then well-established Hampden-Sydney College, within walking distance of his home; he attended for only two years, departing in 1806 before receiving a baccalaureate degree. By choosing medicine for his life work, he was following in the footsteps of his father and a distinguished line of ancestors.[5,9] His uncle, Karl Franz Naegle, an obstetrician and gynecologist, whose contributions continue to bear his name, was one of the 18 known to have been doctors. John Peter attended the University of Pennsylvania, where he received his degree in medicine in 1809.[10] While there, he studied under one of the most distinguished medical faculties ever assembled, notably Benjamin Rush, William Shippen, Casper Wistar, and Phillip Syng Physick.

After obtaining his degree, he worked in the Philadelphia Dispensary for one year before returning home to practice medicine with his father. This association lasted until the time of his father's death, on the last day of 1811 or the first day of 1812.

We do not know how long Peter remained in the area after his father died. Some authors would have us believe he went to Norfolk for military duty in the War of 1812, that he arrived at the onset of the conflict, and remained there for a period of two years. During that time, we are told, he served as a surgeon in the United States Army, gaining valuable professional experience by treating casualties resulting from military engagements.[11,13] Dr. Johnston said that Mettauer "once made a settlement, which proved to be a brief one in Norfolk," but no evidence has been found to indicate that he was in the military service at that time. An announcement in the *Norfolk Gazette* on January 4, 1815, however, tells of his association with his brother, Francis Joseph, in the practice of medicine. This was not the first newspaper notice of one of the Mettauers in that city; six months before, on July 27, 1814, Francis Joseph had married Mary Ann Eliza Marsden, and on January 26, 1815, there was an announcement of John Peter Mettauer's marriage to Mary Woodward. Both brides were of prominent Norfolk families; their fathers were members of the town council. Peter and Mary's first child, Sarah Eliza, was born in Norfolk in 1816, and Francis Joseph, their first son, in 1818.

When and why the two brothers left Norfolk, we were not absolutely certain. Francis Joseph is listed in the 1820 United States census as residing in Peters-

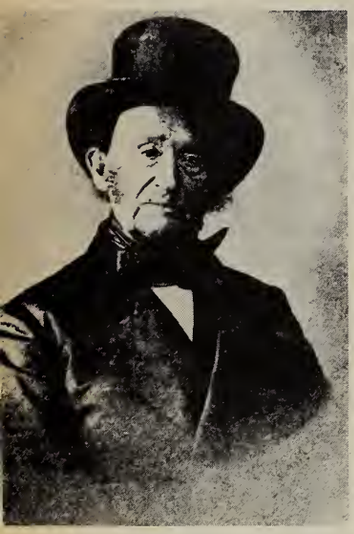
Doctors J. P. & F. J. METTAUER,

HAVING associated themselves together in the Practice of Medicine, make a respectful tender of their professional services to the inhabitants of Norfolk and its vicinity. They have taken for their stand the house formerly occupied by Dr. Hodges, on Main-street, nearly opposite to Mrs. Davis's boarding house, where they will be constantly found.

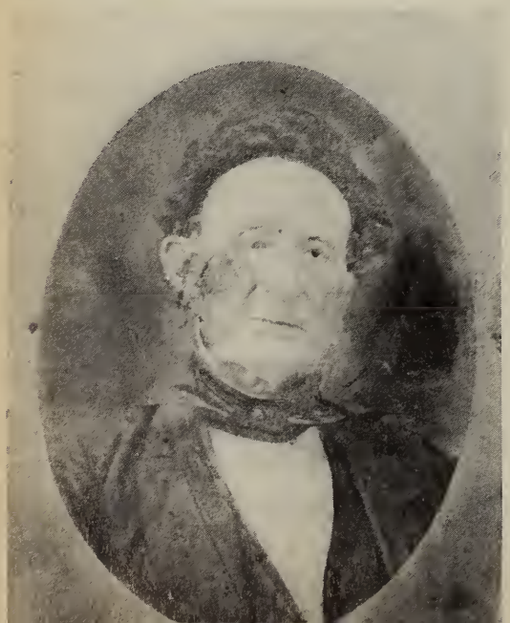
☞ They will take two or three Pupils.

January 4, 1815.

Announcement in the *Norfolk Gazette* tells of Mettauer's association in practice with his brother.



Above, Mettauer wears the high silk hat that was his trademark. *Courtesy Virginia State Library and Archives.* In the watermarked photograph below, taken when Mettauer was 83, he appears to be wearing a wig. *From the author's collection.*



In 1986 Mayor G. Antony of Soultzbach-les-Bains took this photograph of the house built in 1771 by John Peter Mettauer's grandfather.

burg; John Peter is not listed, arousing speculation that he may still have been living in Norfolk, maybe residing with Mary's parents. Documents confirm that the family returned to Prince Edward by 1823. In that year Peter's beloved Mary died. Her body was returned to Norfolk, where on December 27, 1823, an announcement in the *American Beacon* informed that a funeral service for Mary Woodward Mettauer was preached in the Methodist church. Although Peter married three more times, in his will he acknowledged endearment to Mary by requesting that her letters to him be placed in his grave.

In choosing to return to Prince Edward County, the young doctor was emulating his father, who with his superior medical education and cultural background[4,9,14] had appreciated the uniqueness of the rural community. When the father settled in Kingsville, the nearby Prince Edward Courthouse was a crossroads where travellers going north and south, east and west, came to a well-known meeting place; among them were such statesmen as John Randolph and Patrick Henry, who became patients of Dr. Joseph Mettauer.

Following his return home, Peter Mettauer experimented with the use of metallic sutures, reporting a case of successful repair of a recto-vaginal septum. Here we see Peter furthering the work of Professor Physick.[16] During that time he also prepared a manuscript on typhus fever.[17] His reputation spread beyond the local community, and he was offered the chairmanship of the Department of Surgery at Washington University School of Medicine in Baltimore, which he accepted in 1835.[18] After two years he resigned and returned to rural Prince Edward County, where, along with maintaining a large medical practice, he organized and served as professor and administrator of a medical school, the Prince Edward Medical Institute, which later became affiliated with Randolph-Macon College.[19]

Manuscripts now available portray his broad knowledge of the then current diagnostic and therapeutic principles, his scientific enthusiasm, and profound ingenuity. His literary contributions included these medical subjects: epilepsy, scarlet fever, cholera in children, puerpera, menorrhagia, dysentery.[20–25] "He was, also, the original suggestor of employment of iodine in the treatment of scrofula," said Johnston, his first physician biographer.[1]

His surgical accomplishments have been even more highly esteemed. In the days before there were trained assistants, knowledge of antisepsis, and the benefit of general anesthesia, Dr. Mettauer performed many surgical procedures, some by techniques of his own design, others by accepted techniques that he improved upon. He was a pioneer in many technically difficult surgical endeavors while working alone in a rural environment. Furthermore, he prepared manuscripts describing in detail his procedures. He is said to have published 55 scientific articles.

Of all his accomplishments, none did more to relieve human suffering than the method he devised to repair a vesico-vaginal fistula. Now almost unheard of, in those days it was a frequent debilitating complication of childbirth that destroyed the normal life of an untold number of young mothers. In the very early days of modern medicine, in this country and abroad, one of the most constantly sought goals by leading gynecologists was a means of correcting this life-threatening condition. In 1838 Dr. Mettauer, utilizing techniques he devised and instruments he designed, accomplished the first successful repair reported in the United States.[26] He also reported his method in detail, affording others a means of repeating his success. Among them was the renowned J. Marion Sims. "That he influenced the great Sims, as I believe he must have done, is sufficient glory for a country surgeon," observes Dr. Rucker.

For his original work in congenital deformities, including cleft palate[27] and hypo- and epi-spadias,[28] Mettauer has been acclaimed "America's First Plastic Surgeon."[12] In an article depicting his work in ophthalmology he was described as "a genius of his time."[29] Among the innumerable other operative procedures performed by him are: correction of urethral stricture, removal of stones from the urinary tract, and removal of the parotid gland.[30–32] He was one of the first to ligate a carotid artery[33] and resect a maxilla.[34]

More than 100 years have passed since his death in 1875, yet Dr. Mettauer continues to be known by the citizens of Prince Edward County. He is best remembered as the good doctor who always wore the high silk hat. One daughter is reported to have said she never saw her father without his hat on.[35] A photograph taken of him when he was 83 years old showing him without the high hat but certainly wearing a wig was given to the author by Mrs. Marguerite Campbell Bacon of Norfolk, whose grandfather as a boy often drove Dr. Mettauer on his rounds. By requesting in his will that he be buried with his tall hat on, he not only created problems during his last rites, as he was over six feet tall, but it served as a stimulus to more legendary tales.

Of his children, three sons and three daughters lived to adulthood. Descendants survive today. Dr. Edward Mumford, the youngest son to reach adulthood, moved to Florida, where the name was spelled several different ways, including Mettair.[36] All three sons became physicians; the two older, Francis Joseph and Henry Archer, assisted their father in teaching at the medical school he organized.

Peter Mettauer continued to practice medicine until several days before his death at 88 years on November 22, 1878. He was a man of integrity and culture with much dignity of manner. He was made an honorary

member of several medical societies, served as a delegate to the American Medical Association, and was given an honorary master of science degree by his alma mater, Hampden-Sydney College.

Probably his greatest tribute, greater because it was paid during his lifetime, was made by one of America's most brilliant surgeons, Thomas Dent Mütter, who declared him, "Facile princeps [easily the first] of the medical and surgical profession of the world." On his death it was written in the *American Journal of Medical Science*, "He is accredited with more improvements in operations and inventions of instruments to date than any other man." One hundred years later Dr. Benjamin Sheppard wrote, "A genius of his time, he gave Virginia and America a dynamic chapter in advancing medicine."[29]

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Help for a troubled friend is only a phone call away.

If you suspect a colleague is experiencing problems with alcohol or drug abuse, don't contribute to the "conspiracy of silence," call The Medical Society of Virginia's Physicians' Health and Effectiveness Committee. A non-punitive approach through rehabilitation *is* an alternative. Your report will be kept confidential. Ask for Jeanne Douglas at MSV headquarters, (804) 353-2721.

ABSTRACTS

These are abstracts of papers to be presented at the 1989 regional meeting of the Virginia Chapter, American College of Physicians, in conjunction with the Virginia Society of Internal Medicine on March 4 in Williamsburg. Dr. Oscar E. Edwards is program chairman.

Dynamic Respiration Dependent Pseudostenosis of a Coronary Artery Bypass Graft. Charles Vaughan, MD, and Joseph Robbins, MD, *Norfolk.*

A 47-year-old gentleman with evidence of coronary ischemia underwent coronary angiography which revealed a proximal tight stenosis of a saphenous vein bypass graft. However, the following day, angiography prior to angioplasty of the lesion revealed full patency of the vessel during full expiration and tight stenosis of the vessel during full inspiration. Simultaneous pressure tracings proximal and distal to the lesion failed to demonstrate any significant change in the translesional pressure gradient during respiration indicating that the lesion was probably hemodynamically insignificant. The implication of this finding however is significant in that it represents yet another possible pitfall in the interpretation of coronary angiography films.

The Role of Platelets in Myocardial Ischemia. G. Stouffer, MD, M. E. Williams, MD, and R. S. Gibson, MD, *Charlottesville.*

Coronary artery occlusion is a dynamic process involving atheroma, platelets and vascular endothelium. Clinical evidence of the importance of platelets can be seen in the trials of the thrombolytic agents, in the data supporting the use of platelet inhibitors after coronary artery bypass grafting or angioplasty, and in the recent U.S. and Canadian trials demonstrating a decreased incidence of myocardial infarction in patients taking aspirin. Other studies have revealed increased platelet aggregability and breakdown products in patients with unstable angina, and that intracoronary infusion of platelet activators (e.g., ADP or epinephrine) can precipitate myocardial infarction.

We describe a 63-yo man with stable angina who was admitted for elective splenectomy for refractory ITP diagnosed four months earlier. His initial platelet count was 3000/mm^3 but rose steadily with IV Gamma Globulin 400 mg/kg/day for 4 days. He subsequently developed unstable angina at a platelet count of 111,000/mm^3; cardiac catheterization showed a high grade LAD lesion. Thus, this patient's profound thrombocytopenia appeared to have protected him from unstable anginal symptoms.

Detection of Plasma DNA by Counterimmunoelectrophoresis (CIE), a Rapid Screening Test for Pulmonary Emboli (PE). Jill S. Vargo, MD, Daniel M. Becker, MD, John S. Davis IV, MD, et al, *Charlottesville.*

Previously we reported that plasma DNA was found in 83% of patients with PE using a rapid, simple and inexpensive method, CIE. Since the workup of PE involves time-consuming and expensive tests, a rapid specific blood test would be desirable. As part of a prospective study of all suspected PE patients at our institution, we reexamined the diagnostic value of plasma DNA. As part of a study of lung scans in PE, we obtained plasma samples from 121 out of 148 entries. CIE was performed on each sample against anti-DNA from a patient with systemic lupus erythematosus. The CIE gave consistent well-defined precipitin lines at 0.75 μg/ml; in all plasma tested, no lines developed after treatment with DNase or blocking of the anti-DNA with standard DNA. When done, pulmonary angiography was the standard test for comparison; otherwise high probability (HPLS) and normal (NLS) lung scans were used. This data was used to calculate the sensitivity (sens) of the test.

Plasma DNA	HPLS/+PA	NLS/−PA
+	18	4
−	4	22

sens. = 82% spec. = 85%

If patients with ≥ 3 days of PE symptoms are excluded the sens. increases to 90%. This data supports our previous observation that in patients who present with acute symptoms suggestive of PE, the detection of DNA increases the likelihood that a PE has occurred.

Henoch-Schönlein Purpura Following Influenza Vaccination: Successful Treatment of Progressive Renal Insufficiency with High-Dose Pulse Steroids and Cyclophosphamide. Alan Rolfe, MD, and David Dresner, MD, *Portsmouth.*

Henoch-Schönlein purpura (HSP), a systemic necrotizing vasculitis characterized by the syndrome of nonthrombocytopenic purpura, arthralgias, abdominal pain, gastrointestinal bleeding, and glomerulonephritis, has been temporally associated and is a rare complication of influenza, cholera, yellow fever, paratyphoid A and B, and smallpox vaccination. We report the first case of a young adult who developed all the classic manifestations of HSP after split-dose influenza vaccination.

The patient presented with palpable purpura, petechiae, and arthralgias. He rapidly developed colicky abdominal pain, intractable nausea and vomiting, fever, and *Branhamella catarhalis* sepsis. Skin biopsy showed perivascular and vessel wall IgA by immunofluorescence. Endoscopy demonstrated diffuse severe gastritis and duodenitis. Moderate renal insufficiency developed rapidly. A renal biopsy disclosed focal proliferative and exudative glomerulonephritis. Immunofluorescence confirmed the presence of 3+ mesangial IgA deposits and trace IgM, IgG, and C3 consistent with HSP renal disease. After treatment with high dose pulse steroids and cyclophosphamide the patient experienced rapid clinical improvement with the resolution of proteinuria and normalization of the serum creatinine.

Familial Terminal Complement Deficiency and Recurrent Meningococcemia. R. Duncan Hite, MD, Gerald R. Donowitz, MD, and W. Michael Scheld, MD, *Charlottesville.*

Deficiencies of serum complement are extremely uncommon (.03%) in general practice. However, in patients with systemic *Neisseria* infection, terminal complement deficiencies are noted to be as frequent as 10-15%. We report a characteristic and illustrative case of terminal complement deficiency.

The patient was a 19-year-old Oriental female who presented with fever, myalgias, stiff neck and petechiae with positive blood and CSF cultures for *N meningitidis*. The patient had a similar episode 30 months prior, and a sibling had recently died from fulminant meningococcemia. Our patient was successfully treated with penicillin. Complement analysis revealed a C8β deficiency. Two siblings were found to have a similar deficiency. C8 deficiency is the most common of the terminal complement deficiencies. C8β deficiency is typified by recurrent *N meningitidis* infections and is most commonly seen in Caucasians. Overwhelming disease and mortality as seen with this patient's sister is uncommon. The mild course demonstrated in our patient is more typical.

As a result of this patient and our review of the literature, we suggest that patients with *N meningitidis* infection warrant evaluation for complement deficiency.

Ehrlichiosis, a Diagnosis to Be Considered in Virginia. D. Alec Lindley, MD, and C. J. Schleupner, MD, *Roanoke/Salem.*

Ehrlichia canis, an intraleukocytic parasite of wild and domestic animals in the family Rickettsiaceae, has recently been found to be a human pathogen. Clinically, it causes an illness similar to Rocky Mountain spotted fever (RMSF), but usually without a rash. The diagnosis is confirmed by finding intraleukocytic bacteria on a stain of peripheral blood and by serology. We describe a case of a 44-year-old white male who presented with fever of two weeks duration accompanied by headache, arthalgias, malaise, cough, leukopenia, and mild elevations of liver enzymes. The patient had a history of tick exposure approximately 2 weeks prior to onset of symptoms. The patient's fever and clinical illness responded promptly to doxycycline; a convalescent serum specimen demonstrated a rise in specific *E canis* antibody to a titer of 1:40,000.

E canis represents another tick-transmitted infection and should be considered in patients with a febrile illness and documented or possible tick exposure which is otherwise unexplained, especially in patients without a rash or serologic evidence of Rocky Mountain spotted fever.

***Cunninghamella Bertholetiae* in a 62-Year-Old Immunocompetent Male.** Stuart Zeilender, MD, and Dave Drenning, MD, *Richmond.*

Cunninghamella bertholletiae is a saprophytic fungus usually associated with severe life threatening infections in immunocompromised hosts. There are 11 previous cases reported in the literature, with all patients having underlying diseases that were likely to compromise immune defenses. Patients typically have invasion blood vessel wall invasion by the organism with subsequent infarction of the tissue perfused by the involved vessels. We report the first case of *Cunninghamella* associated with an apparently immunocompetent patient. A 62-year white man was admitted with a right upper lobe abscess cavity, diffuse interstitial lung disease and a right pleural effusion. *Cunninghamella bertholletiae* was repeatedly grown from the pleural effusion, bronchial washings, sputums and at autopsy cultures of the lung parenchyma and abscess cavity were also growing the organism. No malignancy or other immunocompromised state was revealed at autopsy.

An Unusual Presentation of Limited Wegener's Granulomatosis. Scott Yagel, MD, and Neil Duval, MD, *Portsmouth.*

We report a case of biopsy-proven Wegener's granulomatosis in a 19-year-old otherwise healthy male. The patient presented with a nonproductive cough and fever, and was found to have multiple cavitary pulmonary lesions, from which anaerobic bacteria were cultured. The patient eventually developed Raynaud's phenomenon and leukocytoclastic vasculitis. He had no evidence of upper airway involvement, clinically or by extensive diagnostic evaluation. Aside from brief microscopic hematuria which spontaneously resolved, renal involvement was absent. Biopsies of skin, muscle and sural nerve were nonspecific. Review of open lung biopsy by the AFIP yielded the diagnosis.

It is felt that to establish a diagnosis of Wegener's granulomatosis, disease must be present in two of the following: upper respiratory tract, lower respiratory tract, kidney. Biopsy must confirm the diagnosis in at least one site. Further, it has been noted that lower respiratory tract disease is unusual without upper tract

involvement. Our patient defies both these maxims.

A Chyloma Presenting as a Posterior Mediastinal Mass: Previously Unreported Complication of Cardiopulmonary Resuscitation. William D. Frazier, MD, *Charlottesville.*

A chyloma is an extrapleural mediastinal collection of lymph resulting from disruption of the thoracic duct. To my knowledge, this is the first reported case of a chyloma with an associated chylothorax secondary to cardiopulmonary resuscitation (CPR). A 75 y/o man had a cardiac arrest at home. He required CPR for 12 minutes before a countershock restored a spontaneous pulse. On admission, a head CT revealed a large left subdural hematoma. Despite operative drainage, the patients' neurologic status remained very poor. Chest x-rays obtained during the first 19 days of hospitalization were normal except for left rib fractures. However, on hospital day 22, a follow-up chest x-ray showed a large, left posterior mediastinal mass and a left pleural effusion. Thoracentesis revealed clear, straw-colored exudative fluid with a lymphocyte count of 137,640/mm^3. Cultures and cytology were negative. A pleural fluid triglyceride level was 134 mg/dl and a sudan red stain was positive for fat globules. The patient was maintained on parenteral hyperalimentation, which was begun on hospital day 8, for a total of 6 weeks. His chyloma and chylothorax resolved. This case illustrates 4 salient points: (1) a chyloma may present as a posterior mediastinal mass, (2) chylous fluid does not necessarily have a milky appearance, especially in the patient who is not eating, (3) a chylothorax may have an extremely high lymphocyte count. This case represents the highest lymphocyte count yet reported in a chylothorax. (4) Cardiopulmonary resuscitation can cause thoracic duct disruption.

Tums-Alkali Syndrome: Severe Symptomatic Hypercalcemia from Excessive Tums Ingestion, a Report of Two Cases. Ramon Matawaran, MD, and Herschel Estep, MD, *Norfolk.*

Milk-alkali syndrome was first described in 1923 by Hardt and Rivers as a complication of the use of the Sippy regimen for the treatment of acid-peptic disease. Since the introduction of H2 blockers, they have become the mainstay in the treatment of peptic-ulcer disease. As a result, milk-alkali syndrome has become an uncommon cause for hypercalcemia.

We present two cases of severe hypercalcemia in two female patients. These patients were both seen within a 6-week period and gave a history of ingestion of an average of 5-6 g $CaCO_3$/d in the form of Tums. They both presented with an acute change in mental status. A detailed work up failed to reveal any other cause for the hypercalcemia. Correction of their hypercalcemic states resulted in marked clinical improvement in both.

How to Report AIDS and HIV Infection in Virginia

Who should report? Every Virginia physician is required by law to report any case or suspected case of AIDS under his or her care. HIV infection is reportable by law in Virginia when the physician needs the local health department's support in patient counseling and epidemiologic tracking. Reports are kept confidential, as the law specifies.

What should be reported? The presence of a reliably diagnosed disease at least moderately indicative of an underlying cellular immune deficiency, with no other known underlying cause of cellular immune deficiency nor any other cause of reduced resistance associated with that disease, should be reported as AIDS.

Only patients who have positive blood tests for HIV antibodies as demonstrated by at least two enzyme-linked immunosorbent assays (done in duplicate at the same time or singly at different times) and another testing procedure, such as the Western blot, should be reported as having HIV infection.

When should I report? As soon as possible after you first provide care for the patient.

Where should I report? To the local health department serving the jurisdiction in which your practice is located.

Prepared for VIRGINIA MEDICAL by the Virginia Department of Health

Carbon Monoxide Poisoning in Indoor Ice Skating Arenas

Richard K. Miller, MD, Mary C. Ryan, MD, and Paul Bilowus, BA,
Fairfax, Virginia

EXPOSURE to fumes from a gasoline powered ice resurfacer in an indoor ice skating arena in Fairfax, Virginia, resulted in at least one documented case of moderate carbon monoxide poisoning in an employee as well as symptoms of carbon monoxide toxicity in patrons using the ice skating rink. The circumstances surrounding this occurrence and the corrective measures taken are described in this report.

While elevated ambient carbon monoxide levels due to these resurfacers have been reported previously in Massachusetts, Pennsylvania and Colorado, individual case reports of poisoning were not described.[1–3] Intensive maintenance procedures, increased ventilation and close followup for compliance at indoor ice arenas with gasoline powered ice resurfacers has been advised. However, the introduction of an electric powered ice resurfacer at the ice arena in Fairfax resulted in permanent elimination of the hazard.

Case Report

Shortly after midnight, a 16-year-old male employee in an indoor ice skating arena developed severe headache and dizziness. Difficulty concentrating gradually increased to the point where he was barely able to count to ten. He became extremely fatigued and was unable to walk. He had been doing janitorial work at the arena almost continuously for ten hours that day. The employee had been in good health previously, was a nonsmoker, and did not have a history of frequent or severe headaches.

A diagnosis of carbon monoxide poisoning was established that night at a local emergency room. While the employee did not have the typical cherry red color of the lips, the diagnosis was suspected because of a coworker's prior experience at a different ice rink and a report of malodorous fumes at the arena indicating exhaust accumulation. The patient's carboxyhemoglobin (COHb) level was 30%; the blood specimen was obtained about one-half hour after the employee left the ice arena. After treatment with 100% oxygen inhalation for an hour, he became asymptomatic and was sent home.

For several days after this incident, the employee experienced problems concentrating in school and found himself unable to perform some language exercises in English class which he had done previously. No long-term sequelae were reported after a period of several months. These findings are based on a conversation with the patient and a telephone contact with his mother. Formal testing was not performed. The patient continued to attend high school, remained with the high school orchestra, and returned to his job at the ice arena.

Upon diagnosis of this case, the emergency room staff contacted the Fire Department, the Fairfax County Health Department's Air Pollution Control Division which had jurisdiction in this case, and the city's mechanical inspector. Carbon monoxide levels above 100 ppm were found throughout the arena that night by an air pollution control engineer from the Health Department using an Ecolyzer Model 2100 portable carbon monoxide analyzer. The peak capacity for measurement with this standard screening device is 100 ppm, and that peak was always reached—and presumably exceeded—in the environment. The Occupational Safety and Health Administration (OSHA) has set a limit of 50 ppm maximum eight-hour exposure average to protect workers in at-risk environments.[4]

The elevated carbon monoxide levels at the ice arena were attributed to two problems. First, the gasoline powered ice resurfacer, which is driven over the ice routinely every one to two hours between 5 AM and 11 PM, was emitting excessive carbon monoxide. Second, there was insufficient ventilation at the ice arena, which allowed the carbon monoxide to accumulate.

Headaches had been a relatively frequent complaint at this ice arena for months prior to the above episode. Several children developed gastrointestinal distress on the day the employee became ill, and many skaters and nonskating employees experienced severe headaches. An outbreak of flu was initially suspected, but, as learned through discussions with skaters at the arena, those with symptoms became well within hours after leaving the arena. In retrospect, these complaints were viewed as probable indicators of lower levels of carbon monoxide toxicity.

Corrective measures at the ice arena were recommended by the Air Pollution Control Division and instituted immediately. Maintenance work on the resurfacer was done that day, and a new catalytic converter was installed. A faulty ventilating pipe for the heating system was replaced, the air exchange rate increased, and, in addition, a new ventilation system was designed for the arena. The ice resurfacer was scheduled to be warmed up 8–10 minutes prior to use, and the exhaust pipe was vented to the outside through an exhaust hose during warm-up. A continuous sam-

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pling analyzer (MSA-LIRA-2025) was left at the arena for monitoring. Over a period of weeks, the level of ambient carbon monoxide dropped to a mean of 23 ppm.

Because of the technical and cost problems involved with increased ventilation at the arena, as well as a desire to lower ambient carbon monoxide levels even further, the owners of the arena purchased a nonpolluting electric powered ice resurfacer.[5] With this resurfacer, ambient carbon monoxide levels dropped to an average of 1 ppm, typical of outside air.

While no complaints had been received from patrons or employees, a second ice arena in Fairfax County was tested for ambient carbon monoxide levels because of the problem previously encountered. (These are the only ice arenas in the county.) A gasoline powered ice resurfacer was in use at this arena, and again significantly elevated levels of carbon monoxide were detected. Structural ventilation defects were not noted. Conversion of the gasoline powered resurfacer to propane was in progress at the time. With subsequent use of the propane powered resurfacer and provision of a faster rate of air exchange, ambient carbon monoxide levels decreased from a mean of 48 ppm to 12 ppm. Continued monitoring was instituted.

Discussion

Carbon monoxide is naturally present in the blood due to catabolic processes, producing carboxyhemoglobin (COHb) concentrations up to 0.8%. Smokers have higher levels of COHb than the general population; values of 5% to 10% have been reported. Toxicity is due to the fact that hemoglobin has a higher affinity (240X) for carbon monoxide than oxygen. Because the resulting COHb is incapable of carrying oxygen, many organ systems are affected by hypoxia.

Additional mechanisms of toxicity may involve binding of carbon monoxide to such hemoproteins as cytochrome oxidase, myoglobin, tryptophan deoxygenase, and tryptophan catalase.[6] Since the cytochrome oxidase systems are also the site of great metabolic activity, the organs with the highest metabolic rates (e.g., the heart and central nervous system) are affected the most by carbon monoxide. Thus, carbon monoxide affects the body in three ways:

1) inhibition of oxygen transport;
2) reduction of oxygen delivery to the tissues;
3) impairment of oxygen utilization by the tissues.

Complications of carbon monoxide toxicity affect almost all organ systems. The heart is involved early, since extra effort is required to deliver an increased volume of blood to poorly oxygenated tissues. This problem is exacerbated by direct effects of carbon monoxide on myoglobin. At carboxyhemoglobin levels of 10%, shortness of breath on vigorous exertion may be noted. Other cardiac manifestations of carbon monoxide over-exposure are sinus tachycardia, atrial and ventricular dysrhythmias and conduction defects. The mechanisms for these abnormalities are not entirely understood but may include acidosis, anoxia and hemorrhage in the conduction system.

The neurologic effects of carbon monoxide toxicity are among the initial symptoms and follow a fairly well-defined pattern. Impairment of perception may begin at carboxyhemoglobin levels as low as 5%. Coordination is affected at levels between 15% and 20%. Headaches develop at 20% and fatigue, disturbances of judgment, dizziness, and visual problems occur at COHb levels of 30%.

Confusion, muscle weakness, and fainting are reported at carboxyhemoglobin levels of 40% to 50%. Loss of consciousness, convulsions, and death after long exposure occur at 60% to 70% COHb levels. A level of 80% can be immediately fatal. Death at much lower levels has been reported with prolonged exposures and in particularly sensitive individuals.[7] Neurologic relapse and deterioration have been reported to occur in some patients 2–9 days after exposure. Late and potentially severe neuropsychiatric symptoms have also been reported following apparent recoveries.

Development of symptoms of carbon monoxide poisoning varies based on the concentration of carbon monoxide to which the individual is exposed and the duration of exposure. The Environmental Protection Agency (EPA) has set a standard for outdoor air at 9 ppm maximum 8-hour exposure average and 35 ppm maximum 1-hour exposure, neither to be exceeded more than once a year. Based on exposure analysis, this standard is estimated to keep 99% or more of the sensitive population below a 2.1% COHb level. Recent review of research concerning the medical effects of carbon monoxide exposure resulted in retention of this standard by the EPA.[6,8]

Levels of carboxyhemoglobin rise over exposure time until an equilibration is reached between blood COHb and the concentration of carbon monoxide in the air. About three hours are needed at rest for COHb to reach 50% of the equilibrium value. Exposure to an ambient carbon monoxide level of 100 ppm may result in a COHb level of 4% after one hour and 16% when equilibrium is reached. Exercise and smoking decrease the time required to reach equilibrium.[8]

Carbon monoxide toxicity is a gradually reversible process with time. When removed from an environment with high carbon monoxide levels, a patient may eliminate half of his absorbed carbon monoxide in about five hours and 20 minutes in fresh air. This half-time can be decreased to 1 hr 20 min with administration of 100% oxygen by mask.[9]

Increased susceptibility to the effects of carbon monoxide exposure is present in certain individuals and under special circumstances. Children and teenagers appear to develop toxicity at lower exposure concentrations than do adults. They may experience gastrointestinal symptoms more frequently.[10] Expo-

sure during pregnancy can result in fetal death, while the mother may recover.[11] (The effects of maternal smoking on fetal growth and development are considered to be related to carbon monoxide exposure in utero.) Patients with a history of angina pectoris may develop severe and prolonged chest pains at low exposure levels.[6] The presence of chronic obstructive pulmonary disease also exacerbates the effects of carbon monoxide.[12]

The clinical presentation at low levels of exposure is nonspecific, with complaints such as headache, nausea, vomiting and sometimes exertional dyspnea. The symptoms are often of several days' or even weeks' duration, which makes an occupational or environmental etiology less likely to be considered. Several family members may be affected, resulting in a diagnosis of "viral syndrome". Failure to diagnose carbon monoxide poisoning may allow the patient to return to the exposure, sometimes with very serious consequences. Therefore, carbon monoxide poisoning should be included in the differential diagnosis of patients presenting to the emergency department with headache, dyspnea, nausea or altered levels of consciousness. Questions should be asked about car exhaust leaks, home heating systems and other vocational or avocational activities that may be associated with high carbon monoxide levels.

Multiple factors are present in indoor ice skating arenas which increase the toxic effects of elevated ambient carbon monoxide levels. Children and adolescents constitute the majority of ice arena patrons. They are performing vigorous exercise and are involved in an activity requiring excellent coordination to prevent serious injury to themselves and others. A study of ice hockey players at Harvard demonstrated that exercising athletes can develop levels of carboxyhemoglobin associated with impaired perception and coordination when performing in ambient air concentrations of carbon monoxide of about 22.5 ppm after a playing time of only 93 minutes.[13]

Because ice skating arenas are frequently open 18 hours daily and skaters and employees spend many hours at them, often more than eight hours at a time, duration of exposure is regularly prolonged. Many employees and most ice skaters are not aware of the risk of carbon monoxide exposure and/or toxicity. Therefore, early warning signs are ignored, mild cases not diagnosed, and persons with special risk factors exposed. Pregnant women not only ice skate but may be employed as instructors.

Recommendations

The following measures are recommended to prevent carbon monoxide toxicity in indoor ice skating arenas.

1) Standards for indoor air quality, including carbon monoxide levels, should be established nationally for the general public.

2) When there is a risk of exposure to levels of carbon monoxide above those recommended by the Environmental Protection Agency, employees and the general public should be warned by a clearly visible warning sign posted at the entrance to the arena by the management.

3) All indoor ice skating arenas using gasoline powered ice resurfacers and other gasoline powered machines should be monitored regularly. Carbon monoxide monitors may be placed at the arena by the management for daily review with a plan established for frequent notification of and spot checks by the local regulatory authority.

4) Introduction of electric powered ice resurfacers should be encouraged. Propane powered resurfacers may provide a less costly, acceptable but preferably interim option.

The authors gratefully acknowledge the assistance of Dr. Cecile Rose.

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VIRGINIA MEDICAL

EDITORIAL

Fraud and Abuse Statutes

For those practitioners of medicine who deal with Medicare and Medicaid a new regulation seems to be promulgated each month. Obviously that is not really the case, but new interpretations and new regulations do appear with alarming frequency. Further, these changes seem to be frequently nebulous and always more constrictive. Consider the draft copy of the proposed regulations concerning the anti-kickback provisions of the Medicare and Medicaid fraud and abuse statutes.

Under the Social Security Act, it is a crime for a physician to offer, pay, solicit or receive kick-backs or rebates under certain circumstances, such as financial relationships which may be linked to patient referrals. Congress has directed the Secretary of the United States Department of Health and Human Services to specify payment practices that will not be treated as a criminal offense under the Social Security Act. The proposed regulations concerning the anti-kickback provisions are being developed in response.

According to Ms. Julia Krebs-Markrich, a former Assistant Attorney General of Virginia, the "safe harbors" included in the draft of the proposed regulations are quite narrow; careful analysis of payment practices not covered by the regulations will be necessary in order to ensure compliance with the law.

To the practitioner: Submit comments as to the appropriateness of the proposed regulations when they are published in the *Federal Register*; if you are in doubt, consult your attorney. E. L. K., Jr.

Self Pity

It had been a busy Saturday morning in the office, my two partners were out of town, I had both nasal congestion and pounding sinuses with my URI, my cough was slightly better because I had practiced all night, and now I had to see a patient at a nursing home.

I dread seeing patients at nursing homes. As an ophthalmologist, I feel naked and inadequate without my ton of equipment, without my big chair, without my gizmos. Bare hands and just an ophthalmoscope do not security give.

Also, almost nothing depresses me more than seeing so many physically and mentally incapacitated people in the last stages of their lives. I admire people who can work in nursing homes because I do not have that kind of mental stamina.

But there was no way out. Mr. Smith had a sore red eye and was in no shape to be bought to our office. I puttered about the office, dictated a letter or two, then could procrastinate no longer. How I wished that it was my weekend off so that I could be in the mountains, that my cold was gone, that I felt good, that I did not have to go to the nursing home.

Mr. Smith had severe dementia from Alzheimer's disease, but this time he was not combative, so I quickly saw that he had a mild bacterial conjunctivitis. I wrote some orders for antibiotic eye drops, put on my coat against the cold fall drizzle, stuck my black bag under my arm, and slowly walked down the long hall toward the exit. My frontal sinuses were killing me. I was going home and get in bed and skip lunch.

In the door of the room next to the exit stood a very old, frail, man with a terribly twisted spine. He looked up at me with obvious envy and said, "I wish I felt half as good as you look."

Henry S. Campell, MD

OBITUARY

• **John Richard Saunders, MD,** retired Lynchburg obstetrician/gynecologist; Medical College of Virginia, 1935; age 78; died November 26, 1988. He had been president of the Lynchburg Academy of Medicine and the Virginia Obstetrical and Gynecological Society.

• **James H. Gamble, MD,** longtime family physician in Lovingston; University of Virginia School of Medicine, 1953; age 71; died July 11, 1988.

• **Robert A. W. Latimer, Sr., MD,** Manassas; Georgetown University School of Medicine, 1949; age 62; died July 10, 1988. He was a general practitioner.

• **Herman Harrison Braxton, Sr., MD,** for 55 years a general practitioner in Chase City; Johns Hopkins University School of Medicine, 1932; age 82; died November 18, 1988.

• **Ghulam Hussain Surhio, MD,** Blacksburg ophthalmologist; Liquat, Pakistan, Medical School; age 50; died of a massive coronary on October 2, 1988.

• **John Otto Boyd, MD,** Roanoke; Medical College of Virginia, 1941; age 74; died September 2, 1988. His specialty was emergency medicine.

• **Fen'n Ernest Victor, MD,** family physician in Roanoke; School of Medicine and Pharmacy of the University of Haiti, Port au Prince, 1950; age 64; died September 6, 1988.

• **Charles Edward Sutton, MD,** Richmond; Howard University College of Medicine; age 63; died May 16, 1988. He was a general practitioner.

• **Lester Edwin Dunman, MD,** longtime Pearisburg internist; Medical College of Virginia, 1935; age 76; died September 16, 1988, in Atlanta.

• **Walter C. Beck, MD,** retired pathologist; George Washington University Medical School, 1947; age 67; died October 18, 1988, in Vienna, Austria. From 1957-1966 he was associate pathologist at Roanoke Memorial Hospital. A brother, Ralph E. Beck, MD, practices pathology in Richmond.

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Physician's Guide to the Natural Death Act

From the time it became effective in 1983, the Natural Death Act (Virginia Code §54-325.8:1) has offered a statutory "safe harbor" for the Virginia physican who complies in good faith with its provisions.

The Act defines "terminal condition" as "a condition caused by injury, disease or illness from which, to a reasonable degree of medical certainty, (i) there can be no recovery and (ii) death is imminent."

"Life-prolonging procedure" is defined by the Act as "any medical procedure, treatment or intervention which (i) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (ii) when applied to a patient in a terminal condition, would serve only to prolong the dying process; however, nothing in this act shall prohibit the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain."

These are the steps the law requires:

1. A patient makes a declaration directing the withholding or withdrawing of life-prolonging procedures in the event of a terminal condition. If the declaration is written, it must be signed by the patient and two witnesses, neither of which may be the patient's spouse or blood relative but one of which may be the physician.

If the declaration is oral, it is valid only (i) if made after the patient has been diagnosed as having a terminal condition and (ii) if it is made in the presence of a physician and two witnesses, neither of which may be the patient's spouse or blood relative.

2. If the patient has made a valid declaration and is competent, the attending physician must then certify in writing that the patient has a terminal condition before withholding or withdrawing a life-prolonging procedure.

3. If the patient has made a valid declaration but is "comatose, incompetent, or otherwise physically or mentally incapable of communication," the attending physician must certify in writing that the patient has a terminal condition and must also have one other physician examine the patient and do likewise before withholding or withdrawing a life-prolonging procedure.

4. In the case of a patient who is comatose, incompetent or otherwise physically or mentally incapable of communication and who has not made a written or oral declaration, the Act designates these persons, listed in order of priority, with whom the attending physician must consult and agree prior to withholding or withdrawing a life-prolonging procedure:

1) any guardian or committee judicially appointed on behalf of the patient;

2) anyone designated in writing by the patient to make the treatment decision;

3) the patient's spouse;

4) an adult child of the patient or a majority of the children who are reasonably available for consultation;

5) the parents of the patient;

6) the nearest living relative of the patient.

If no one in the first category is "reasonably available, willing and competent to act," the physician may go to the next priority, and then the next, until an appropriate person is located.

But when the physician must turn to any of the family members in the last four categories, the physician (i) must insure that there are two witnesses present when the treatment decision is made with those family members, and the patient's spouse and blood relatives may not serve as either of these witnesses, and (ii) must get consent from two persons in any of the last four categories if two are reasonably available.

Two points should be emphasized. First, the Act does not apply to patients who are under 18 years of age. Second, if a physician does not want to direct the withholding or withdrawing of life-prolonging procedures as authorized by this Act, he has no obligation to do so; he must, however, offer to transfer the patient to another physician.

The Act does not eliminate any immunity a physician already may have under the common law.

Attorneys Sandra Kramer and Allen C. Goolsby III developed this legal information for the June 1983 issue of Virginia Medical. *It has been slightly revised for subsequent reprintings.*

Still available at Virginia Medical is the patient brochure with the declaration that implements the Natural Death Act. To receive up to 100 copies free of charge, send your order to the Executive Editor, 4205 Dover Road, Richmond VA 23221.

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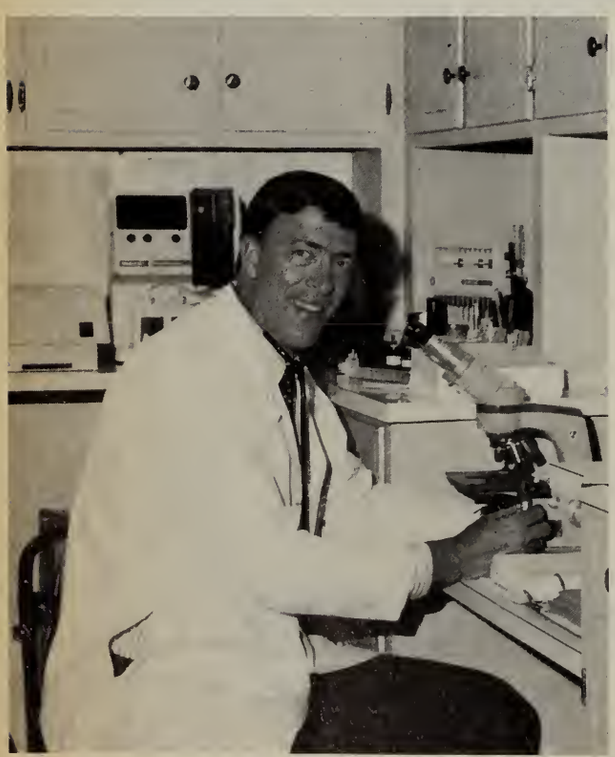
WHO'S WHO

The new president of the American Society of Internal Medicine likes to call himself a mountain boy. He is **Dr. James G. Nuckolls** of Galax, Virginia. "There's an old saying in the mountains of Virginia," he told ASIM members in accepting the presidency, "If you see a turtle sitting on a fence post, you can bet it didn't get there by itself." At 49, Dr. Nuckolls is believed by the Society to be its youngest president ever. He is definitely the first Virginian to lead the 23,000-member national specialty society.

Jim Nuckolls spent his undergraduate years as a basketball scholar at Davidson College. He earned his medical degree at Duke University School of Medicine, where he also served his residency. At Duke he was one of the first Carnegie-Commonwealth Clinical Scholars (now the Robert Wood Johnson Clinical Scholar program) and was named chief resident in 1971. (Now, as an associate professor of clinical medicine, he heads up the Duke outreach program in Galax.) After his residency at Duke, he enlisted with the United States Public Health Service and was assigned to the Center for Disease Control in Atlanta, where he and three colleagues examined an epidemic in Pontiac, Michigan. They turned out five research papers that described what was then known as Pontiac fever and contributed six years later to the identification of *Legionella pneumophila*.



President Nuckolls in his lab

His colleagues thought he was crazy when he decided to set up shop in Galax, a rustic community 90 miles southwest of Roanoke. With a population of just over 6,000, it is not the place one would expect to find a hotshot doctor from Duke, but Dr. Nuckolls is a sixth-generation Galaxian and still has the saddlebag his physician great-grandfather took on house calls. When asked why he went back, Dr. Nuckolls deadpans, "I almost had to." He started in 1972 with a solo practice in the basement of an abandoned Baptist church, but now has three associates, **Drs. Len B. and Linda T. Lastinger** and **Dr. Allen M. Laws**, who practice with him as Blue Ridge Health Associates.

In 1977 he was named ASIM's Young Internist of the Year, and he has been a member of the Society's board of trustees since 1982. He has also served for ten years on the board of directors of the Robert Wood Johnson Clinical Scholars program. His organizational credentials include the Southwestern Virginia Medical Society, The Medical Society of Virginia and the American Medical Association. At the AMA meeting in Chicago in December, he caucussed with the MSV delegation every morning at 7 AM and was "well-informed and articulate," according to delegation chairman Percy Wooton, on that hot acronymn, the RBRVS.

He is the director of the intensive care unit at the 149-bed Twin County Community Hospital, which adjoins his office building, and is a founder and president of the Blue Ridge Highlands Nursing Home of Galax.

With its mountains and lakes, Galax is the perfect place for an athletic doctor such as James Nuckolls. Tall (6'6") and lanky, he still plays a mean game of basketball, with a local men's team, and begins his day three times a week with 6 AM aerobics. Every Tuesday is a ski day, snow permitting.

Dr. Nuckolls met his wife Mary Lily while he was at Davidson and she at Duke. Mary Lily is office manager for Blue Ridge Associates and the founder of what will be the first licensed daycare center in Galax, Apple Pie Kids, slated to open in spring 1989. They live on a farm at the foot of the mountains beside the New River where Dr. Nuckolls fishes for pike, rock bass and catfish; in earlier years he was often joined by one or the other of his three children, but now they are all in college.

As president of the ASIM he is scheduled for a speech about twice a month. He says he doesn't like public speaking but admits, "The more I do it, the bigger a ham I get."

He looks serious when he talks about his goals for ASIM, especially physician payment reform. He says physicians must establish their own payment guidelines before the government steps in ("If we don't do it, someone else will"). Dr. Nuckolls believes specialty differentials and geographic variation of fees have caused the demise of the primary care physician in particular and the country doctor in specific. "We need to make those fields more attractive," he says, "because that's what the public needs."

—SANDRA MCKINNON

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IN THIS ISSUE:

No sooner had the "Injured Infants Act," as it is familiarly known, passed the General Assembly in 1987 than it began to generate discussion, and the discussion continues to date. On page 96 you will find another in a long line of Letters to the Editor protesting the act's funding mechanism. On page 119 you will find a report of a legislative subcommittee to study both the funding mechanism and the act's articulation of birth-related neurological injury. In between, beginning on page 114, you will find the results of a study of the act's potential efficacy as a compensatory device and deterrent to liability suits; this is the first such research, and the two young women who conducted it have already moved into a second phase, an analysis of the act's probable cost.

No one takes a keener interest in all this discussion and study than attorney Sandra L. Kramer, who was there when the Injured Infants Act was passed. For almost a decade Ms. Kramer helped Allen C. Goolsby 3rd run the MSV lobbying team; she negotiated with lawmakers, wrote many of the bills the Society introduced, was party to countless MSV committee meetings on matters legal/legislative. Now she has been appointed to succeed Goolsby as The Medical Society of Virginia's chief counsel and head lobbyist, although Goolsby will continue to serve the Society as "outside" counsel. Previous MSV counsels have operated on a consulting basis. It is a sign of the times that Sandra Kramer will be a fulltime, inhouse attorney, with offices in downtown Richmond and at MSV headquarters.

Taylor Dabney

Counsel Kramer with Del. John C. Brown (left) and Dr. Kenneth W. Tuck, chairman, MSV State Legislative Committee

MSV Phone Book

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LETTERS

Advocates sending editorial to "every legislator and lawyer"

The editorial on the profession of medicine in the December issue of VIRGINIA MEDICAL[1] is the most outstanding piece of writing I have ever seen concerning the problems that confront us in the practice of medicine.

The solution concerning the changing of the tort system so that malpractice litigation can be limited to avoidable personal injury is also absolutely essential if the high cost of medicine can be controlled. The editorial should be forcibly nailed to the forehead of every legislator and lawyer in the country.

My congratulations for such a brilliant and succinct piece of writing.

Joseph G. Fiveash, Jr., MD
400 West Brambleton Avenue
Norfolk VA 23510

1. Kendig ELjr. The profession of medicine. Va Med 1988;115:588-9

Proposes taping, distributing conversations with third parties

Like most doctors I am increasingly disturbed by intrusions into medical practice, in the name of "cost-containment," by representatives of the insurance companies and other third parties to the doctor-patient relationship. By contract they have arrogated to themselves the "right" to peruse patients' charts and otherwise to obtain detailed and privileged clinical information about them. Armed with this information, they then decide who is to be admitted to the hospital, what tests and treatment they will receive, and how long they will stay in the hospital. They are exerting increasing pressure on us to cut corners in ordering tests and treatment and to discharge patients prematurely. In short, they have thrust themselves into the role of uninvited and unqualified participants in the care of our patients.

In the vast majority of cases, patients have no idea what is happening behind the scenes, and if things go wrong it is the doctor and the hospital they blame. Indeed, the decisions made by the third parties are presented to the public as "quality assurance" and the doctors and hospitals are portrayed as villains who must be watched to prevent dishonest and greedy behavior. Moreover, the business executives who

Continued page 96

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For information on symptoms and treatment of overdosage, see full prescribing information.
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select the plans to be offered to their employees often have no real knowledge of how the plans will affect the quality of the health care they and their employees will receive. Ultimately, they may not care as long as the bottom line is favorably influenced.

It is important to be sure that our patients know and that their employers know. It is time to get the word out to the public at large. Only we can do it, and it is our duty to inform them in unmistakable terms. It seems to me the only way to accomplish this is to get these procedures into the fresh air of public scrutiny.

With that in mind, I have bought a tape recorder and a telephone pickup device so I can record my conversations with third parties. I inform them at the beginning of the conversation that it is being recorded and that it is my plan to send a copy of the tape-recorded conversation to the patient and to the employer who selected the health insurance plan. I plan eventually also to release a number of these tapes to the media.

I have obtained a written legal opinion from the Attorney General of the State of Virginia that it is lawful to obtain such tapes and to use them as I describe. My purpose in writing is to urge every practitioner in the state to begin taping these conversations, too. It seems to me if enough of us do this, it cannot be long before there is a public outcry to return control of medical care to the doctors, where it belongs.

I.N. Sporn, MD

Suite 302, 1400 Westwood Avenue
Richmond VA 23227

Wants action to get rid of "unfair and unjust bill"

Once again we have been billed for the second annual assessment of $250 levied on Virginia physicians to fund the Birth-Related Neurological Injury Compensation Act. Once again our noses are rubbed into this malodorous and obnoxious "no fault" bill. How long must we in the medical profession remain in the indecent "Sim's position" for this annual proctoscopic exercise?

This bill is a legislative gargoyle which should be put out of its misery. This "assessment" is blackmail in designer clothing.

Ridding physicians of this unfair and unjust bill demands only a modicum of imagination. Funds should be drawn from state revenues or welfare resources. The state enjoyed a budgetary surplus last year and introduced a state lottery during calender '88.

With each year this tax will become a more entrenched, ossified addiction. Currently, payment can be made only with maximum protest. Action is needed now, this year!

John E. Termini, MD
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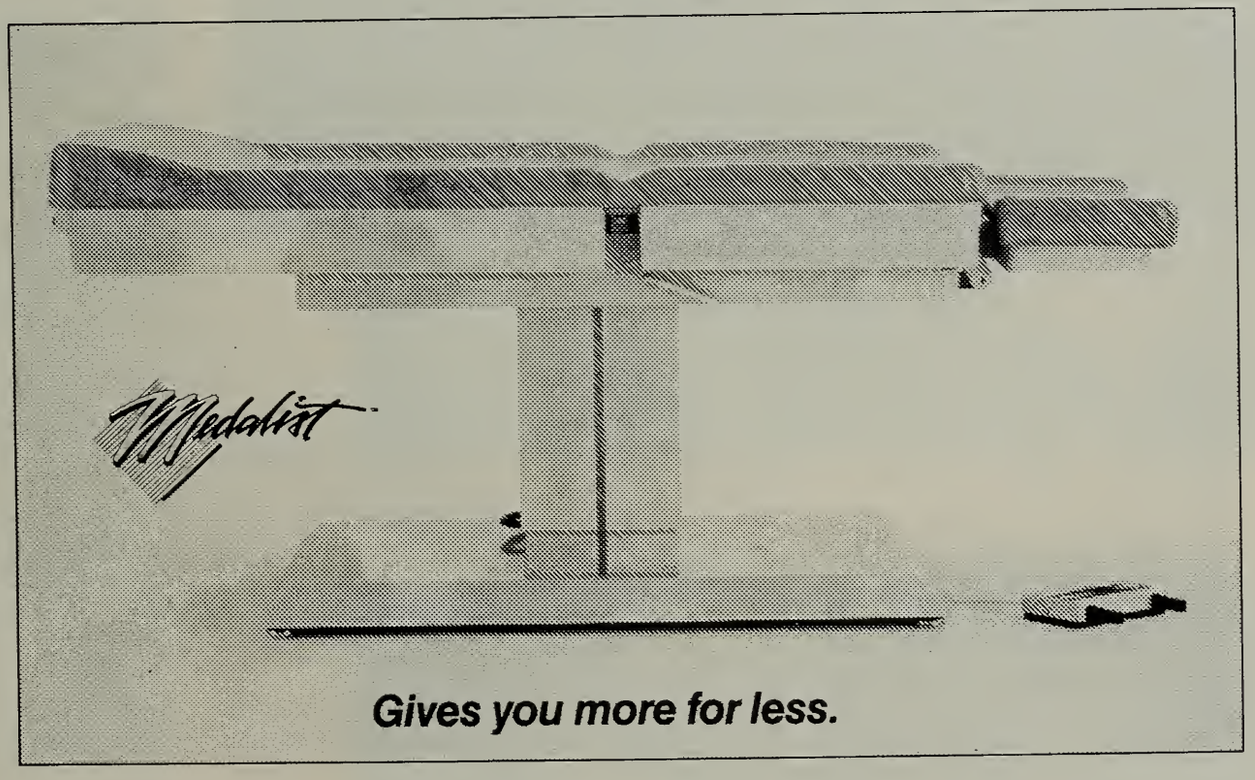

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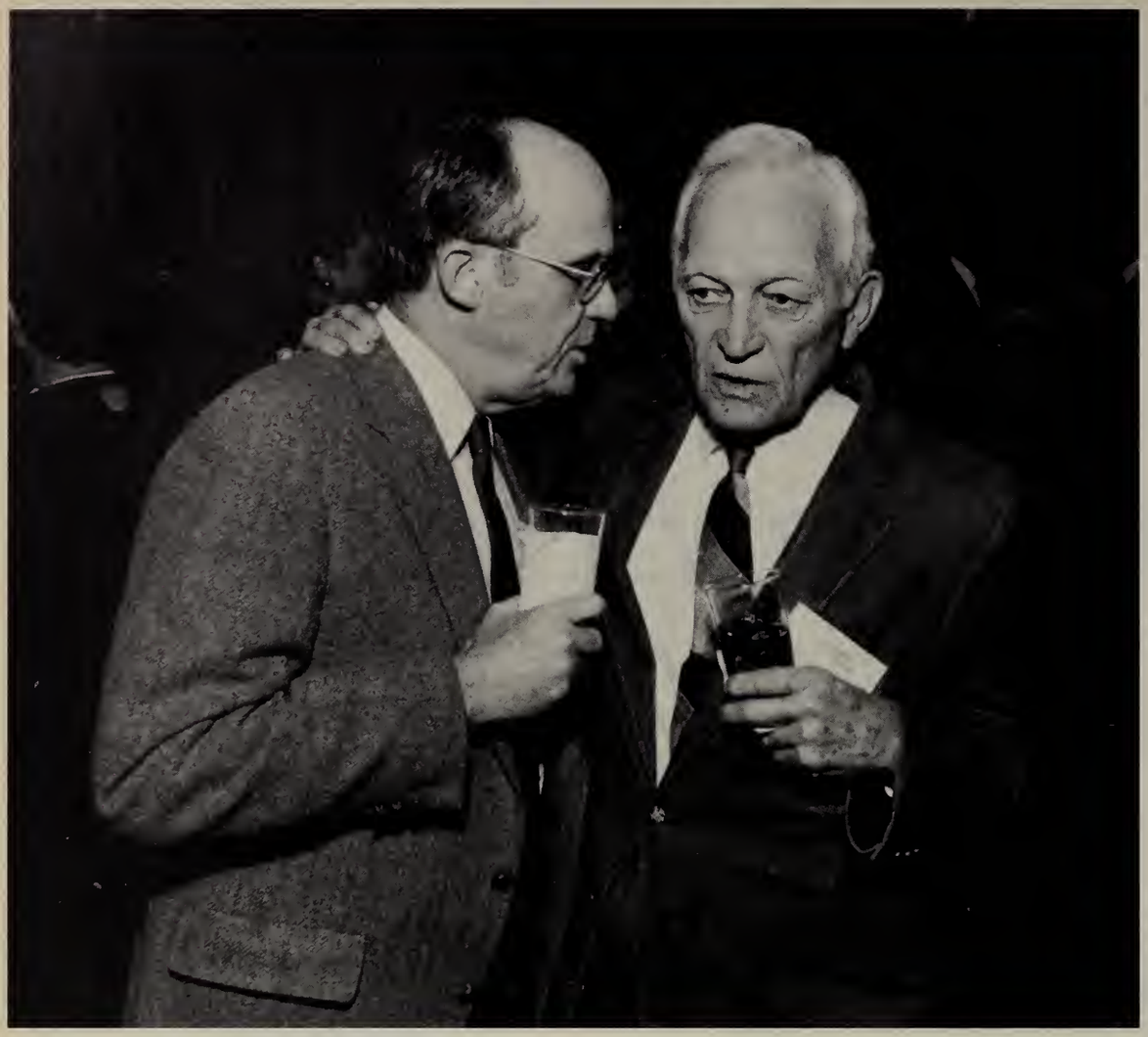

Dr. Henry C. Cambell, Martinsville (left), and Speaker of the House A. L. Philpott

Popular Party

The annual VaMPAC reception on the eve of the General Assembly's opening session has become a popular party with state legislators, their aides, and other people with clout at Virginia's Capitol. For this year's event, the seventh in the series, an estimated 350 persons piled into the ballroom of the Commonwealth Club in Richmond. Some of the 99 legislators who came appear in these pictures and all are listed at the right.

From the Senate

HUNTER B. ANDREWS
(D-Hampton)
W. ONICO BARKER
(R-Danville)
JOSEPH B. BENEDETTI
(R-Richmond)
DANIEL W. BIRD, JR.
(D-Wytheville)
ROBERT L. CALHOUN
(R-Alexandria)
EDWINA P. DALTON
(R-Richmond)
MARK L. EARLEY
(R-Chesapeake)
JOSEPH V. GARTLAN, JR.
(D-Mason Neck)
VIRGIL H. GOODE, JR.
(D-Rocky Mount)
CLARENCE A. HOLLAND
(D-Virginia Beach)
EDWARD M. HOLLAND
(D-Arlington)
RICHARD J. HOLLAND
(D-Windsor)
R. EDWARD HOUCK
(D-Spotsylvania)
JOHNNY S. JOANNOU
(D-Portsmouth)
BENJAMIN J. LAMBERT III
(D-Richmond)
J. GRANGER MACFARLANE
(D-Roanoke)
THOMAS J. MICHIE, JR.
(D-Charlottesville)
EMILIE MILLER
(D-Fairfax)
KEVIN G. MILLER
(R-Harrisonburg)
YVONNE B. MILLER
(D-Norfolk)
FRANK W. NOLEN
(D-New Hope)
ROBERT E. RUSSELL
(R-Bon Air)
RICHARD L. SASLAW
(D-Springfield)
ELLIOT S. SCHEWEL
(D-Lynchburg)
ROBERT C. SCOTT
(D-Newport News)
WILLIAM A. TRUBAN
(R-Woodstock)
CHARLES L. WADDELL
(D-Sterling)
STANLEY C. WALKER
(D-Norfolk)
WILLIAM C. WAMPLER, JR.
(R-Bristol)

From the House

A. L. PHILPOTT, SPEAKER
(D-Bassett)
WATKINS M. ABBITT, JR.
(D-Appomattox)
ROBERT W. ACKERMAN
(D-Fredericksburg)
G. STEVEN AGEE
(R-Roanoke)
GEORGE F. ALLEN
(R-Charlottesville)
JAMES F. ALMAND
(D-Arlington)
ROBERT T. ANDREWS
(R-McLean)
ROBERT S. BLOXOM
(R-Mappsville)
VINCENT F. CALLAHAN, JR.
(R-McLean)
MARY T. CHRISTIAN
(D-Hampton)
WHITTINGTON W. CLEMENT
(D-Danville)
SHIRLEY F. COOPER
(D-Yorktown)
HOWARD E. COPELAND
(D-Norfolk)
J. PAUL COUNCILL, JR.
(D-Franklin)
FREDERICK H. CREEKMORE
(D-Chesapeake)
E. HATCHER CRENSHAW, JR.
(R-Richmond)
GLENN R. CROSHAW
(D-Virginia Beach)
JEAN W. CUNNINGHAM
(D-Richmond)
ROBERT K. CUNNINGHAM, SR
(R-Springfield)
JAY W. DEBOER
(D-Petersburg)
ALAN A. DIAMONSTEIN
(D-Newport News)
V. EARL DICKINSON
(D-Mineral)
JOHN G. DICKS III
(D-Chesterfield)
JAMES H. DILLARD II
(R-Fairfax)
J. ROBERT DOBYNS
(D-Dublin)
WILLARD R. FINNEY
(D-Rocky Mount)
V. THOMAS FOREHAND, JR.
(D-Chesapeake)
ARTHUR R. GIESEN, JR.
(R-Waynesboro)
RAYMOND R. GUEST, JR.
(R-Front Royal)
MARK W. HAGOOD
(R-Halifax)
FRANKLIN P. HALL
(D-Richmond)
EMMETT W. HANGER, JR.
(R-Mt. Solon)

Frank D. Hargrove
(R-Glen Allen)
George H. Heilig, Jr.
(D-Norfolk)
Phillip Hamilton
(R-Newport News)
William J. Howell
(R-Fredericksburg)
Thomas M. Jackson, Jr.
(D-Hillsville)
G. C. Jennings
(D-Marion)
Jerrauld C. Jones
(D-Norfolk)
Gladys B. Keating
(D-Franconia)
Jack Kennedy
(D-Norton)
Mary A. Marshall
(D-Arlington)
Stephen H. Martin
(R-Richmond)
Alan E. Mayer
(D-Lincolnia)
Glenn B. McClanan
(D-Virginia Beach)
Dorothy S. McDiarmid
(D-Vienna)
Frank Medico
(R-Alexandria)
William S. Moore, Jr.
(D-Portsmouth)
Harvey B. Morgan
(R-Gloucester)
Thomas W. Moss, Jr.
(D-Norfolk)
W. Tayloe Murphy, Jr.
(D-Warsaw)
Phoebe M. Orebaugh
(R-Broadway)
Lewis W. Parker, Jr.
(D-South Hill)
Harry J. Parrish
(R-Manassas)
Harry R. Purkey
(R-Virginia Beach)
Ford C. Quillen
(D-Gate City)
Linda M. Rollins
(R-Leesburg)
John A. Rollison III
(R-Woodbridge)
C. Jefferson Stafford
(R-Pearisburg)
Warren G. Stambaugh
(D-Arlington)
S. Wallace Stieffen
(D-Hampton)
Walter A. Stosch
(R-Richmond)
Robert Tata
(R-Virginia Beach)
A. Victor Thomas
(D-Roanoke)
Marian Van Landingham
(D-Alexandria)
Mitchell Van Yahres
(D-Charlottesville)
John Watkins
(R-Midlothian)
S. Vance Wilkins, Jr.
(R-Amherst)
Clifton A. Woodrum
(D-Roanoke)
Jane H. Woods
(R-Fairfax)

Sen. Daniel W. Bird, Jr., and Health Commissioner C. M. G. Buttery

Del. Gladys B. Keating (left) with Dr. and Mrs. Anthony M. Longo, Alexandria

Dr. C. Barrie Cook, Falls Church, and Del. Dorothy S. McDiarmid

Photographs by Taylor Dabney

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WHO'S WHO

When the winner of the Louise Obici Memorial Hospital's annual award is presented next month, an internist/hematologist will step forward to receive it. He is **Dr. G. Watson James 3rd,** who has been hanging round the Medical College of Virginia in Richmond since his student days in the Class of '43. He is the 25th recipient of the award, given "for outstanding contributions to the medical profession." The presentation is to occur at the hospital's clinical conference on April 5 in Suffolk.

Dr. James' reputation as a top-notch clinician and researcher knows no geographical boundaries. He has been on the national committee of the American Federation for Clinical Research, is a fellow of the International Society of Hematology, and is at home in the rarified proceedings of the American Society for Clinical Investigation. For his alma mater he has been chairman of the Division of Hematology (1958–1983), and he holds full professorships in both medicine and pathology. As author or coauthor, he has published 41 articles, most of them in journals with worldwide readerships.

But above all, emphasizes a colleague, "Watson James takes great care of his patients."

Gov. Gerald L. Baliles has appointed **Dr. Charles W. Crowder, Jr.**, South Hill, to the Governor's Advisory Board on Medicare and Medicaid, and **Dr. Lee Richard Brock**, Fredericksburg, to the Medical Advisory Board for the Department of Motor Vehicles.

Dr. Fran DuRocher, Springfield internist, has been elected president of the Metropolitan Washington area branch, American Medical Women's Association.

March ushers in the championship bicycling season, and in Williamsburg **Dr. Camilla M. Buchanan** and her racing bike are reaching a peak of training. This year there's a special urgency to the 30 high-speed hours per week they spend together: in Pensacola, Florida, last year, Dr. Buchanan won first in the Women's Criterion Master's Cycling Championship in the 40+ age category, and she'll be defending her title this year. She has won other races, but the national first was particularly gratifying.

In training for a major competition, Dr. Buchanan cycles about 250 miles a week. Last summer she traveled every Thursday to the Afton Mountain area in preparation for mountain competition in Idaho. It's important for a serious biker to represent a racing club in the national events; she rides for the Tidewater Cycling Association. Her associate in obstetrics/gynecology, **Dr. Mary Kay Dineen**, covers for her when she's out of town for a race.

Camilla Buchanan was active in intercollegiate athletics in her undergraduate days at William and Mary. She married, went into teaching, reared two children, decided to enter medicine, earned an MD degree at the Medical College of Virginia, Class of 1976, then also trained at MCV. She began running in the late 1960s and ran for 16 years, working up to marathon distance. Entering the Sandman Triathlon in Virginia Beach, she found she enjoyed cy-

Cycling Champ Buchanan

New Officers for Component Societies

These Virginia physicians have been elected to leadership posts by their component medical societies. All but three of them are members of The Medical Society of Virginia.

Alexandria Medical Societry, **Dr. William M. Stone,** president; **Dr. Merrill F. Prugh,** secretary.

Augusta-Highland County Medical Society: **Dr. Davis S. Klein,** president; **Dr. Brian Kennedy**, secretary.

Danville-Pittsylvania Academy of Medicine: **Dr. Arthur W. Whitehurst,** president; **Dr. Douglas W. Shiftlett,** secretary.

Fredericksburg Area Medical Society: **Dr. J. D. Brock,** president; **Dr. Robert B. Vranian,** secretary.

Loudoun County Medical Society: **Dr. Randall L. Harrington,** president; **Dr. Flinton Callahan II,** secretary.

Northern Virginia Medical Society: **Dr. Stephen H. Martenson,** president; **Dr. John H. Armstrong,** secretary.

Patrick-Henry Medical Society: **Dr. W. Daniel Price 3rd,** president; **Dr. G. Samuel Hurt,** secretary.

Prince William County Medical Society: **Dr. Frederick W. Parker 3rd,** president; **Dr. Stephen L. Ferlazzo,** secretary.

Richmond Academy of Medicine: **Dr. Warren W. Koontz, Jr.,** president; **Dr. John M. Daniel 3rd,** secretary.

Roanoke Valley Academy of Medicine: **Dr. Richard J. Grayson, Jr.,** president; **Dr. William J. Dichtel, Jr.,** secretary.

Rockingham County Medical Society: **Dr. T. Keith Vest,** president; **Dr. C. Newkirk Sheap,** secretary.

Virginia Beach Medical Society: **Dr. Ramnath Nayak,** president; **Dr. Bruce C. Dundon,** secretary.

cling more than running. In only her third season of competition biking she won the national title.

Her athletic regimen helps her keep her work as physician in perspective, she told Wilford Kale, who interviewed her for the *Richmond Times-Dispatch*. "The job is important and I want to be the best doctor, but I also realize other things are important."

Such as being the best biker.

Dr. Harry I. Johnson, Jr., Roanoke, has been appointed by Gov. Gerald Baliles to a four-year term on the board of visitors of Virginia Commonwealth University.

Dr. Paul B. Underwood, Jr., professor and chairman of obstetrics and gynecology at the University of Virginia, has been named one of the 107 best doctors for women, according to a nationwide survey conducted by Good Housekeeping magazine. The survey polled 250 department heads and other leaders of ob/gyn at major medical centers.

Named fellows of the American College of Radiology during ceremonies at the annual meeting in Cincinnati were **Dr. Hans O. Riddervold,** Charlottesville, and **Dr. Anas M. El-Mahdi,** Portsmouth.

Dr. William E. Broach III, Danville, has been named a fellow of the American College of Obstetricians and Gynecologists.

For his contributions to the educational programs of the American Academy of Ophthalmology, **Dr. Earl R. Crouch, Jr.,** Norfolk, has received the academy's Honor Award. Dr. Crouch is professor and chairman of the ophthalmology department at Eastern Virginia Medical School.

For his 21 years of service as team physician to the Alleghany High School football team, **Dr. Charles F. Ballou III,** Clifton Forge, was given a plaque and a round of applause prior to the start of the big Alleghany-Covington game. Kenny Higgins, AHS coach, and Ben Hicks, president of the Mountaineer Athletic Club, conducted the ceremony honoring the physician. The team celebrated the occasion by winning the game.

Dr. Alvin J. Ciccone, Norfolk, was named 1988 Family Physician of the Year by the Virginia Academy of Family Physicians.

At Warren Memorial Hospital in Front Royal, **Dr. Elizabeth B. Sherman** and **Dr. Edwin M. Eastham** were honored recently for their "loyal and valuable service to the hospital and the citizens of Front Royal and Warren County."

Dr. Sherman, a native of Luray, earned her MD at the University of Maryland, graduating in 1926 and then completing training for general practice, including a residency in pediatrics at Bellevue Hospital in New York. She joined the medical staff of Warren Memorial in 1942 and was named to the emeritus medical staff in 1983.

Born in Flint Hill, Dr. Eastham was awarded his MD degree in 1943 by George Washington University, where he also served his internship. After service overseas with the Army Medical Corps during World War II, he joined Warren Memorial's medical staff in 1946, with privileges in general medicine and obstetrics, and was appointed emeritus in 1984. He also served as medical examiner and coroner for Warren County.

To **Dr. Thomas K. Hunter**, former dean of the University of Virginia's School of Medicine, went the 1988 Abraham Flexner Award of the Association of American Medical Colleges. The award is given for "significant lifelong contribution to medicine," a criterion admirably met by Dr. Hunter's 27 years in key administrative posts on the Charlottesville campus and his world

leadership in the field of biomedical ethics. Officially retired as of 1980, he continues to keep what he describes as "a little office" at the university and lives in Cismont in the 170-year-old house he and his wife bought 35 years ago.

Elected to fellowship at the annual clinical congress of the American College of Surgeons were **Dr. Martin A. Thiel**, Williamsburg, and **Dr. William A. Liston**, Farmville.

Dr. Leo Goldhammer, Arlington, is to present a paper at the annual meeting of the American Academy of Neurology in Chicago. His title: "Apraxic and Parietal Hand and Their Localizing Value: Tonic, Motor and Visuokinetic Phenomena in Parietal Lob Syndromes."

The Radiological Society of North America's highest honor, the Gold Medal Award, was given to **Dr. Richard G. Lester**, Norfolk, at the society's annual meeting. Dr. Lester, dean and vice president for academic affairs at Eastern Virginia Medical School, is a past president of the society.

Dr. Robert P. Singer, Richmond, was there when the mountain climbers of the 1988 Northwest American Everest Expedition made it all the way to the top of the 29,000-foot peak last October. He was a member of the support system, serving as a doctor at a base camp 11,500 ft above sea level while the climbers pushed on to the ultimate heights.

Dr. Singer had been training for three years for the Everest venture; a dedicated fitness man, he had only to beef up his workouts at the swim and racquet club to which he belongs. In early August he left his Henrico County practice to join the climbers in Katmandu, Nepal, and hike 120 mi to the peak. On October 22, while still on the mountain, he celebrated his 59th birthday. No cake, no candles, but oh my, the view!

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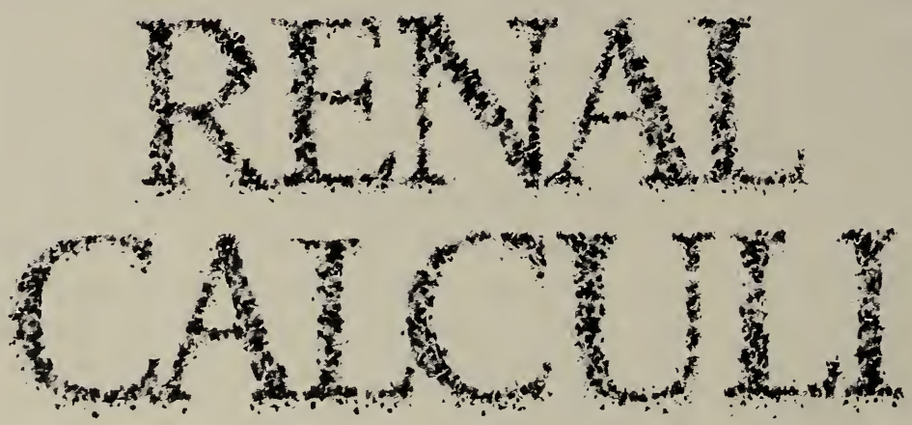

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VIRGINIA MEDICAL
MARCH 1989

Injured Infants Act: Study Compares Definition, Newborn Records

Barbara S. Brown, PhD, and Tamara E. Faulknier, BS,
Richmond, Virginia

In a study of a teaching hospital's newborn records 1986-1987, the definition of severe neurological injury in Virginia's Injured Infants Act was found to be associated with neonatal death, prematurity, and a preexisting maternal condition likely to contribute to poor outcome. The incidence of severe neurologic injury did not approach the prevalence of severe mental retardation and cerebral palsy. Thus the ability of the Act to preempt litigation substantially is questionable, the authors state, and they recommend a broader definition.

When the Virginia General Assembly passed the Birth-Related Neurological Injury Compensation Act in 1987,[1] several questions about the measure's effectiveness were unanswered because of lack of information about the number of infants born each year who would meet the Act's definition of neurologically injured. Practitioners criticized the definition as being too restrictive to deter litigation. Some even questioned if any infants could be found to meet the explicit eligibility criteria. On the other side, policy makers wanted to begin with a conservative definition so that excessive financial burden on the trust fund would be avoided at the outset. Until the effects of broadening the definition were known, it was unlikely that the legal definition could be revised.

To address these issues, the Medical Society of Virginia contracted with the Williamson Institute for Health Studies at the Medical College of Virginia, Virginia Commonwealth University, to conduct a study on the incidence of severely neurologically injured infants and the effect of broadening the definition.

From the David G. Williamson Institute for Health Studies, Department of Health Administration, Medical College of Virginia/Virginia Commonwealth University, where Barbara Brown is assistant professor and coordinator of the Health Care Financing Administration Research Center. Address correspondence to her at Box 206, MCV Station, Richmond VA 23298-0206.

Submitted 1-25-89.

Materials and Methods

The records of infants born at a university medical center between January 1, 1986, and December 31, 1987, and having anoxia at birth were abstracted to identify infants fitting the Act's definition and three alternative definitions of severe neurologic birth injury. Figure 1 shows the enacted and proposed definitions tested. A select task force of the Medical Society chose the three alternatives. Each definition captures different eligibility factors.

Virginia's definition is explicit (only those children who are "permanently nonambulatory, aphasic, incontinent, and in need of assist-

ance in all phases of daily living'' are eligible); while the other three are not.

The Florida definition, enacted by the Florida legislature when it passed a similar law in 1988, differs from the Virginia definition in two ways. It broadens the definition of disability by stating the infant is rendered ''permanently and substantially mentally and physically impaired'' without requiring explicit disabilities. However, it narrows eligibility by excluding preterm infants. The Virginia definition accepts premature infants.

The third definition proposed by the task force, termed Medical Society of Virginia Alternative Definition I (MSVI), is the least restrictive of the definitions. It extends coverage to peripheral nerve damage and eliminates the requirements that impairment be both mental and physical as well as permanent. Like the Virginia definition, it includes premature infants. The definition was proposed after much debate on the effect of maturation on an injury sustained at birth. The expert physicians felt it inequitable to deny assistance to a child for whom the permanency of the severity of injury could not be confirmed until the preschool years. In addition, their clinical experience indicated children could sustain permanent or substantial injury to peripheral nerves without being mentally impaired.

The fourth definition, listed as Medical Society of Virginia Alternative Definition II (MSVII), is the Florida definition with the restriction on premature birth removed.

In all definitions, the cause of injury remained the same as stated in the Virginia Act, ''oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital.''

The sample was composed of infants meeting oxygen deprivation criteria. The criteria were having Apgar scores consistent with asphyxia neonatorum, i.e., scores less than 4 at 1 minute and less than 6 at 5 minutes.[2] The Apgar scores were set at these levels for two reasons. First, case studies of severely neurologically impaired infants born at the facility from 1982 to 1985 indicated the most predictive variables were low Apgar scores at 1 and 5 minutes within this range. This finding was consistent with the literature.[3] Second, it provided a method for identifying the population of infants, as Apgar scores are included on birth certificates filed with the state.

The Virginia Bureau of Vital Statistics provided a list of infants meeting the Apgar criteria who were born between January 1, 1986, and December 31, 1987, at the medical center. Each child's birthweight was also given. Children weighing under 1000 grams (gms) were eliminated from the record review because it was felt that they did not pose a serious malpractice litigation threat. Medical charts and/or discharge summaries of the remaining infants were abstracted by the principal investigator (BSB).

To characterize the infants and gain insight to predisposing or accompanying events associated with severe neurologic damage, the following information was collected on each infant: Apgar score, sex, race, survival, length of hospital stay, diagnoses, mother's age, history of antepartal care, type of delivery, presentation, history of obstetric or delivery complications, positive findings on admission and discharge (either physical examination or diagnostic studies) and hospital charges. Any subsequent hospital or ambula-

Fig. 1. Enacted, Proposed Definitions of Birth-Related Neurological Injury.

VIRGINIA DEFINITION

''Birth-related neurological injury'' means injury to the brain or spinal cord of an infant caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital, which renders the infant permanently nonambulatory, asphasic, incontinent, and in need of assistance in all phases of daily living. This definition shall apply in live births only.

FLORIDA DEFINITION

''Birth-related neurological injury'' means injury to the brain or spinal cord of an infant of term gestation caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

MEDICAL SOCIETY OF VIRGINIA ALTERNATIVE DEFINITION I

''Birth-related neurological injury'' means injury to the brain, spinal cord, or peripheral nervous system of an infant caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital, which renders the infant permanently or substantially mentally or physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

MEDICAL SOCIETY OF VIRGINIA ALTERNATIVE DEFINITION II

''Birth-related neurological injury'' means injury to the brain or spinal cord of an infant caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

Figure 2. Infants by Case for 1986 Meeting Definitions of Neurologically Injured.

Case Number History	86-1	86-2	86-3	86-4	86-5	86-6	86-7	86-8	Totals
APGAR at 1 min	0,0	1,2	1,0	1,3	1,4	1,4	1,4	2,5	
Dx in addition to Asphyxia		SGA RDS	Convulsions	Seizures SGA Mec aspir	*Mec aspiration	Disseminated intravasc hem	Mec in trach	Seizures Mec in trach IGR	
Survival	Deceased (day 1)	Deceased (day 2)	Deceased (day 2)	Deceased (day 5)	Deceased (day 1)	Deceased (day 1)	Deceased (day 1)	Living	
Birth Weight	3 lbs 5 oz	5 lbs 1 oz	7 lbs 2 oz	5 lbs 2 oz	7 lbs 10 oz	3 lbs 5 oz	6 lbs 15 oz	5 lbs 1 oz	
Mother's Age (in years)	22	23	19	Missing	17	16	21	23	
Ante Care	No	Unknown	Yes	Yes	Yes	Yes	Unknown	Yes	
Obst/delv comp	Footling breech PROM Sepsis	None	Mom admitted 2 day **PTD in ketoacidosis	Post term	Mom being tx for Group B strep	G4P3 (note mom's age)	Fever 102.3 F Nuchal cord xl	Hypertension Infarcted placenta	
Type Delivery	C-section	Vag	C-section for fetal distress	C-section when ROM W mec	C-section for fetal distress	"C-section secondary to severe bradycardia lasting 10 min & prob longer"	C-section	C-section	
Definitions (see Fig. 1)									
VA	X	X	X	X	X	X	X	X	8
FLA	0	X	X	X	X	0	X	X	6
HSV I	X	X	X	X	X	X	X	X	8
MSV II	X	X	X	X	X	X	X	X	8
Notes	Uterine contractios on head made extraction difficult On admis cyanot, floppy foul odor	Intubated × 20 for mec. Urine output down secondary to hypoxic insult to kidneys	"Persistent acidosis." Urine output down. No moro, no grasp, no spont move	"Hypoxic encephalopathy." Intubated × 7 for mec	Intubated × 9 for mec. On admis no suck, no grasp, no moro	"Child severely asphyxiated at birth and never responded adequately to vent support"	"Unable to maintain pO2 compatible with life"	At 22 mos operates on 3-5 mos level	

* Meconium
** Prior to delivery

Figure 3. Infants by Case for 1986 With Pending Definitions of Neurologically Injured.

Case Number History	P-86-1	P-86-2	P-86-3	P-86-4	P-86-5	P-86-6	P-86-7	P-86-8	P-86-9	Totals
APGAR at 1 min and 5 min	1,5	2,3	1,5	1,4	2,2	1,1	0,5	1,5	1,5	
Dx in addition to Asphyx that contr to assign	RDS Sepsis	Convulsions Perinatal infec	Hypovolemic shock	Convulsions Fx clavicle Cerebral hem RDS Hydroceph	Intracereb hem RDS Hydroceph Severe BPD*	Premature Intraventric & Periventric hem BPD		Mec in trach Sepsis	Premature Cerebral hem	
Survival	Living	Living	Living	Living	Living	Living	Living	Living	Living	
Birth Weight	3 lbs 4 oz	4 lbs 8 oz	5 lbs 5 oz	2 lbs 13 oz	3 lbs 8 oz	3 lbs 5 oz	5 lbs 5 oz	7 lbs 0 oz	3 lbs 15 oz	
Mother's Age (in years)	28	24	Missing	22	24	33	24	17	Missing	
Ante Care	Missing	Yes	Missing	Yes	Yes	Yes	Yes	Missing	Missing	
Obst/delv comp	Prolapse cord Premature labor	None	Abruptio	Breech Premature labor	Abruptio	Fever PROM	Twins Premature labor Resp dist	ROM** 2.5 days PTD	ROM 2.5 days PTD	
Type Delivery	C-section for fetal distress	Precep in bed	C-section	Vag	C-section	C-section	C-section after forceps delv of Twin A	Missing	C-section for fetal distress	
Definitions (see Fig. 1)										
VA	0	0	X	X	X	0	0	0	0	3
FLA	0	0	X	0	0	0	X	X	0	3
MSV I	X	X	X	X	X	X	X	X	X	9
MSV II	X	X	X	X	X	X	X	X	X	9
Notes	No D/C exam: does say tone normal No info on neuro	On admis hypotonic, no suck or grasp D/C exam WNL	On admis pink, unresponsive to stim, flaccid No D/C exam	At 9 wks musc tone very hypotonic Feeding prob on D/C (d 107) No D/C summary exam	Intracran hem, bilat grade III Shunt insert On vent for 1 mo	Fair tone on D/C Infantile reflexes WNL Shunt insert	Hypotoniclittle spon activ on admis Weaned to RA in 48 hrs No D/C exam	Limp at birth Weaned to RA on d 3 No D/C exam	Mech vent until d 10	

* Bronchopulmonary dysplasia
** Room air

tory care records available were reviewed to confirm the assignment of infants to one or more of the categories.

Because the third definition includes peripheral nerve injury, 54 cases occurring at the facility in the last five years were requested for review on the basis of this diagnosis alone. Forty-six of the 54 charts were found and reviewed.

Results

In 1986, 141 infants were born at the center who met the Apgar criteria. Of these, 66 were eliminated from the record review because they weighed less than 1000 gms. Of the 75 babies meeting the weight criteria, 69 cases were reviewed. For the remaining six, no records were available.

In 1987, 130 infants had Apgar scores within the study range. Of the 93 cases meeting both the Apgar and birth weight criteria, 85 were reviewed. No records were available for eight infants.

Of the 69 cases for 1986, 52 infants had no documented neurologic injury; eight infants met one or more of the definitions and nine infants were designated as "pending." The pending category was added because information in some charts was indicative of severe neurologic injury, but not complete enough to allow definitive assignment to one or more of the definitions. Figure 2 arrays the history and assignment of 1986 infants fitting one or more of the four categories. The infants fitting the categories represent 0.17% of the births at hospital and 0.01% of the Virginia births in 1986. Figure 3 arrays the history of 1986 infants with pending assignments. The notes at the bottom of each figure give chart information that assisted in categorizing the infants.

As can be seen from Figure 3, eight infants met the Virginia definition as well as the two alternative definitions proposed by The Medical Society of Virginia. Prematurity excluded two of the eight from the Florida definition. Only one of the infants is living. Two infants were premature, but of the remaining six term infants, half were diagnosed as being small for gestational age. Only one infant was a vaginal delivery of an uncomplicated pregnancy.

All infants in the 1986 pending group survived. Six of the nine infants were premature. All but one were products of complicated pregnancies. Of the nine infants, four were designated as pending for Virginia's definition, three were considered pending for Florida's definition, and all nine met the alternative definitions.

In 1987, of the 85 cases reviewed, 78 infants had no documented injury. Three infants fit one or more of the definitions. Another four were placed in the pending category. Figure 4 arrays the 1987 infants fitting one or more of the definitions and Figure 5 arrays the 1987 pending cases. The infants fitting the Virginia definition represent 0.07% of the hospital's births and 0.003% of the births for 1987 in Virginia.

Infants fitting definitions in 1987 were products of complicated pregnancies and delivered by cesarean section. Two of the three are still living. Only one infant met the Florida definition because the others were premature by dates. All three infants met the Virginia definition as well as the alternative definitions.

All four infants shown in Figure 5 were pending placement in the alternative definitions only and are living. None of the infants had documented injuries severe enough to be placed in the pending Virginia category. Prematurity made three of the four children ineligible for the Florida definition. All were cesarean section deliveries of mothers with complicated pregnancies.

Of the number of infants born who were likely to have severe neurologic sequelae, very few actually did. The quality of care children at risk for injury receive from their physicians and the hospital in which they are born is a major factor in preventing long-term disability.[4] The hospital attributed the decrease in sample size from 1986 to 1987 to clinical innovations that occurred during the study period, such as administering

Figure 4. Infants by Case for 1987 Meeting Definitions of Neurologically Injured

Case Number History	87-1	87-2	87-3	Totals
APGAR at 1 min	1,5	0,2	1,0	
Dx in addition to Asphyx that contr to assign	Intraventric hem	Feeding prblm Lower nephron nephrosis Hypocalcemia Seizures	Seizures Premat	
Survival	Deceased (day 1)	Living	Living	
Birth Weight	3 lbs 7 oz	8 lbs 5 oz	5 lbs 0 oz	
Mother's Age (in years)	23	25	33	
Ante Care	Yes	Yes	Yes	
Obst/delv comp	PROM	CMV exposure Progesterone exposure	Placenta previa	
Type Delivery	C-section for fetal distress	C-section	C-section	
Definitions (see Fig. 1.)				
VA	X	X	X	3
FLA	0	X	0	1
MSV I	X	X	X	3
MSV II	X	X	X	3
	Unable to maintain pO2	1 umbil artery Central deafness Central blind N/G fed until 3 wks because of poor suck At 3 mo-marked head lag	"Pt remained severely neurologically impaired with hypertonic extremities abnormal auditory potentials minimal visual evoked potential pattern." Mostly N/G fed secondary to poor suck & gag	

Figure 5. Infants by Case for 1987 With Pending Definitions of Neurologically Injured

Case Number	P-87-1	P-87-2	P-87-3	P-87-4	Totals
History					
APGAR at 1 min and 5 min	1,4	1,5	2,5	1,1	
Dx in addition to Asphyx that contr to assign	Periventric hem	Post term SGA	Acidosis Sepsis	Hyperglycemic Hypopotassemia Hyperosmolarity Acidosis	
Survival	Living	Living	Living	Living	
Birth Weight	2 lbs 5 oz	4 lbs 12 oz	3 lbs 8 oz	4 lbs 13 oz	
Mother's Age (in years)	33	24	21	29	
Ante Care	Yes	Missing	Yes	Yes	
Obst/delv comp	PIH*	PIH Obesity	Partial abruptio 3rd trimester bleed Premat labor	PIH Abruptio	
Type Delivery	C-section	C-section for fetal distress	C-section	C-section	
Definitions (see Fig. 1)					
VA	0	0	0	0	0
FLA	0	X	0	0	1
MSV I	X	X	X	X	4
MSV II	X	X	X	X	4
Notes	Weaned from vent on d 5 D/C exam: "neuro nonfocal but questionab improved tone." Did well on oral feedgs. No enlarg of ventricle w bleed	Poor suck when feedg started. D/C exam: neck tone still decreased	D/C exam: "infant remains very letharg."	On admiss tone in UE > LE. Head ultras WNL. Feeding well on D/C	

* Pregnancy-induced hypertension

surfactant to premature infants in the delivery room.[5]

The trend at the hospital was mirrored statewide. Within the two years, the number of infants born with Apgar scores within the study range in Virginia dropped by 9%, while the total number of live births increased by 3%.

The incidence of severe neurologic injury was low. If both the current and pending cases (17 cases) are combined for 1986 for the most lenient definitions (MSVI and MSVII), the incidence is four per 1000 live births. The prevalence of severe mental retardation and cerebral palsy documented in the literature is five per 1000.[3] For 1987, the incidence for the current and pending cases (seven cases) is even lower at two per 1000.

Associated Factors

The proposed function of the Virginia Injured Infants Act, as it is called, is to capture those circumstances that lead to malpractice litigation as a result of uncontrollable events at delivery. Two predisposing factors apart from birthing influenced the incidence of injured infants in this study.

The first of these was prematurity. As can be seen by Figures 2 through 5, the least number of infants fit the Florida definition because preterm infants were ineligible.

Prematurity predisposes an infant to severe neurologic damage and is difficult to isolate as its sole cause when accompanied by low Apgar scores. For example, is intraventricular bleeding in a low birthweight infant caused by premature systems or birth trauma? The answer is not discernible from medical chart data.

Successful outcomes for preterm infants are related to the degree of prematurity. The risk of cerebral palsy for infants weighing 1500 gms (3 pounds 3 ounces) or less is 22 times that of normal birth weight infants.[3] It is estimated that for every 100 infants less than 1500 gms 16% will be seriously or moderately disabled.[4] This rate has not changed despite more neonatal intensive care facilities because very sick newborns who previously would have died now survive.[4] Infants weighing less than 1500 gms made up 63% of the 1986 sample and 50% of the 1987 group.

The second factor associated with infants' neurologic injuries was a maternal preexisting condition. Children in the categories were likely to be born of mothers with placenta abruptio, placenta previa, sepsis and/or hypertension. It is unknown if injured infants delivered of mothers with these obstetric conditions represent typical malpractice cases.

The alternative definitions capture the larger number of infants because they do not exclude prematurity or designate explicit permanent disabilities. Extending eligibility to children with peripheral nerve injury did not increase the number of cases. The children would have been included because of additional problems caused by asphyxia. However, a larger sample may identify children without mental impairment but having residual facial and brachial palsies.

Discussion

From these findings, the ability of the Act as written to preempt litigation is suspect. Since the Virginia definition was associated with death in the neonatal period in 1986-87, it is unlikely to be currently covering a group of living, disabled infants whose families sue because of finan-

cial need to meet their children's health and welfare needs. The children identified as neurologically damaged represented population-based health care problems (prematurity, maternal complications) rather than problems specific to treatment by a physician or in a hospital.

Children falling into the alternative definitions are more likely to survive. The nonspecific nature of the term "substantially mentally and physically impaired" allows for the influence of maturation—but it makes it difficult to establish clear criteria for exclusion from the fund, i.e., what criteria will be used for borderline cases. Requiring only physical impairment or mental impairment did not increase the number of cases because we were unable to identify an infant who was substantially impaired physically and was not also severely handicapped mentally, as indicated by achievement of developmental milestones. This finding is influenced, however, by the age of our sample as well as the limited number of peripheral nerve injuries. Overall, the broadening of the definition did not greatly increase the incidence of neurologic injury even when the pending and current categories were combined.

Our need for a pending category represents an issue for the commissioners of the Injured Infants Act's fund. At present there is no method for dealing with infants for whom the probability of severe neurologic injury is high but the degree of injury unconfirmed or for whom the degree of disability lessens, yet these infants are the survivors. Should criteria be developed to allow placement for a limited time until further evaluation and continued coverage by the fund is decided? If a child is aphasic, incontinent, and in need of assistance in all phases of daily living but starts to walk at 4 years of age, how shall the case be handled?

Within the state a system exists for early case finding of infants likely to have neurologic sequelae after birth. Apgar scores, birth weights, and birth hospital are part of the database maintained by the Bureau of Vital Statistics. The overseers of the Injured Infants Act's Commission can receive names of infants likely to fall into the fund, based on Apgar scores, and can follow these infants through hospital discharge summaries, which further narrow the field of candidates. Further followup could then occur through pediatric neurologists' office records or state agencies providing infant stimulation services. The provider of posthospital care was listed in all the summaries reviewed.

Summary

For this sample of infants, assignment to the Virginia Injured Infants Act's definition of severely neurologically injured was associated with neonatal death, prematurity and a preexisting maternal condition likely to contribute to a poor outcome. The incidence of severe neurologic injury for confirmable cases did not approach the prevalence of severe mental retardation and cerebral palsy for either year. For these reasons, the ability of the Act to substantially preempt litigation is questionable. Expanding the definition to include broader language, i.e., "substantially mentally and physically impaired" was more likely to capture infants surviving the neonatal period and those in the "pending" category. Including peripheral nerve injury in the definition did not significantly increase the number of cases. Florida's definition was most restrictive because it required infants to be term births.

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Subcommittee to Study Act's Definition, Funding

As this issue of Virginia Medical progressed toward the presses, Del. Clifton A. (Chip) Woodrum (D-Roanoke) was successfully shepherding through the General Assembly his resolution to establish a joint subcommittee to study the definition of a compensable injury and the existing funding mechanism of the Virginia Birth-Related Neurological Injury Compensation Act. The subcommittee's goal, Woodrum's resolution read, would be "to determine whether any modification is necessary or desirable." The measure calls for ten subcommittee members: four delegates, two senators, one citizen, and one representative from each of the following: The Medical Society of Virginia, Virginia Hospital Association, and Virginia Society of Ob/Gyn. It calls for the subcommittee to submit its findings and recommendations to the Governor and to the 1990 session of the General Assembly.

Woodrum introduced the Injured Infants Act at the 1987 Assembly and fought hard for its passage (Va Med, May 1987, pp 291-2).

POINT OF VIEW

Payment Reform: "I have changed my mind"

THREE years ago the conservative Reagan administration recognized a need for reform of medicine's fee-driven system of physician payment. The Secretary of Health and Human Services, through the Health Care Financing Administration, contracted with the Harvard School of Public Health to establish a resource-based, relative-value system (RBRVS) of payment. Organized medicine, through the American Medical Association and specialty societies, supplied the individuals for the study. A second phase is now in research.

Initial reaction to the process by both sides, those who were studied and those who did the studying, was not smooth, but subsequent efforts have improved this work relationship. It is the only study of the economics of medicine that approaches the cost of delivery of care as a basis for reimbursement to the provider.

The primary investigators, William Hsiao, PhD, and Peter Braun, MD, had three questions: 1) What are the relative costs of physician services? 2) Can resource costs be measured? 3) Do the final results conform to reality?[1]

The formula RBRVS = (TW) (1 + RPC) (1 + AST) was developed. TW denotes total work, which includes time and complexity of work. Six variables constitute work: time, mental effort, knowledge and diagnostic acumen, technical skill, physical effort and psychological stress. Each of these factors may be different for a given situation, procedure or diagnostic problem. Each may vary between physicians and specialty orientation. RPS represents the relative specialty practice costs. AST is an amortized value for the costs of specialized training.

The data to insert into this formula were obtained from specialty physicians by the investigators, who selected 200 physicians from the AMA masterfile. This is a file of all doctors, and it identifies special interests. Half of this group were to be board certified in the specialty surveyed. The investigation was done by a professional phone-interviewing group. The data obtained from the approximately 60% respondents were evaluated by a panel of peers in the specialty. Cross-specialty correlation was obtained from a panel of consultants.

Vignettes of hypothetical common situations, both cognitive and procedural, were developed by the physicians for an identified specialty, and used as bases for projecting data. They included such vignettes as management and admission of acute pulmonary edema, lumbar puncture of a 5-year-old child with meningitis, emergency surgical consultation for possible bowel obstruction, and uncomplicated, indirect inguinal hernia repair.

The interviewed specialists were asked to estimate the total work according to the six variables given above. Their answers were reviewed by technical consulting groups made up of physicians from specialty societies. Cross-specialty comparisons were made. An extrapolation of measures of work for survey services to other services was developed. (It should be noted that this is an abbreviated overview of a very complex project.)

The Harvard group's report to HCFA, 2,000 pages long, has been summarized in JAMA.[1] The report has been under very careful review by many, and there have been criticisms of the study's methodology and conclusions. Statistical, factual, practical, realistic analysis continues to be performed by the AMA, specialty societies, and various lay organizations. No one has accepted the report as final, but some new system of physician payment is likely to ensue shortly.

ABOUT the same time the Administration established the RBRVS, Congress appointed the Physician Payment Reform Commission. The Commission is totally separate from the Harvard study. Indeed, the Commission studied the Harvard report as it prepared to present to Congress this month its own recommendations for physician payment reform.

The Commission is composed of 13 members, eight of them representing economics (2), public health policy-making (2), insurance (1), registered nurses (1), the American Association of Retired Persons (1), and medical center administration (1). Five physicians, two of them office-based, complete the Commission; they are Dr. Philip R. Lee, San Francisco, the Com-

mission's chairman; Dr. Robert N. Butler, New York; Dr. P. William Curreri, Mobile, Alabama; Dr. John M. Eisenberg, Philadelphia; and Dr. Thomas Reardon, Portland, Oregon. The Commission has held hearings over the past two years.

When testifying for my specialty before the Commission in November, I was impressed at the depth of the questions to the various specialty society physicians and the Harvard study investigators. The Commission members seem to understand the magnitude of the program of payment reform. They are studying the RBRVS system as one of the methods for reform, but they have not accepted the plan and may devise a totally different approach to present to Congress this month.

A PPRC meeting in December included suggestions for how to determine the relative value of visits on a fee schedule and a full report on global services, including a definition of a global package. Log diaries regarding physician office visits and a survey of practice costs and assignment were also on the agenda.

For a meeting last month, the Commission listed these topics for discussion:[2]

Fee Schedule Issues: review and evaluation, RBRVS; coding of visits; standardizing coding for surgical global fees; Commission revision of relative values for work; training costs; specialty differentials; practice costs; geographic multipliers; assignment; transition; updating.

Issues Related to Influencing Volume, Composition and Quality of Services: utilization and quality reivew; clinical research and practice guidelines; physician education and dissemination of practice guidelines; expenditure targets.

Data Issues: data requirements for the fee schedule, practice guidelines and expenditure targets; monitoring access under a fee schedule.

Capitation: Physician risk-sharing arrangements.

INITIALLY I was a strong critic of the Harvard project, but as a consultant to the study over the past two and a half years my opinion has changed. It now appears to me that the investigators are seriously interested in improving the system and are trying to use sensible methods to look at our overall cost of operation in order to help us determine some economic principles for the determination of fees.

Certainly there is in Washington a serious mood for a restructuring of medicine's fee system, and there is a very good probability that both Congress and the Administration will write legislation this summer that will attempt to bring some business-like rationale to our present system. It is plain that a new, sensible system is needed by all—by the patient, the employer, the third-party payer, and the physician. And the RBRVS is not the only system under study. Congress and the Administration are also intent on health care cost containment.

Virginia physicians must be responsive to the rapid changes to come. We must communicate with our constituent representatives in the coming months. We must be ready to assist them in understanding the very difficult legislation that will probably be written this summer. No one really knows what will be developed for physician payment reform, but there will be change. Medicine must respond in a unified, intelligent, reasonable, patient-advocate fashion.

NELSON G. RICHARDS, MD

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Hilar Adenopathy and Positive HIV Antibody Test: Case Report

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THE clinical manifestations of infection with the human immunodeficiency virus (HIV) in patients are protean, e.g. rashes, pneumonitis, diarrhea, and dementia. Any symptom or sign may herald the progression from an asymptomatic state to the clinically defined syndrome of the acquired immunodeficiency syndrome (AIDS). This may involve any one of the various opportunistic infections or neoplastic complications associated with defects in cell mediated and humoral immunity.[1,2] Finding either hilar adenopathy or a skin rash in such a patient would raise concern about one of these opportunistic infections or tumors. However, we report an HIV antibody positive patient with both hilar adenopathy and a rash who later was found to have active sarcoidosis. Also discussed are the similar and contrasting clinical and immunological findings between AIDS and sarcoidosis.

Fig. 1. Acquired ichthyosis on the lower extremities.

Case Report

A 25-year-old bisexual black male was first seen at the Fairfax Hospital in March 1986 after one week of pleuritic chest pain, nonproductive cough, chills and night sweats. He was afebrile. Decreased breath sounds in the right lung field were noted. A chest roentgenogram revealed a 30% right pneumothorax and increased interstitial markings in the upper lung field. Even after the pneumothorax was relieved by chest tube drainage the chest roentgenogram demonstrated a diffuse interstitial infiltrate. A room air arterial blood gas revealed mild hypoxia and an increased A-a gradient (pO_2, 78 mm Hg; pCO_2, 37 mm Hg; pH, 7.40). An HIV antibody test was positive. A fiberoptic bronchoscopy with lavage and biopsy was negative for mycobacteria, fungi and *Pneumocystis carinii*. Oral trimethoprim-sulfamethoxazole was administered, his symptoms improved, and he was discharged.

He was lost to followup until March 1987, when he returned to the Fairfax Hospital with a diffuse pruritic rash over the extremities and chest. He denied dyspnea, cough or fever. On physical examination he was found to have a blood pressure of 130/80 mm Hg, pulse of 84 beats/minute, respiratory rate of 16/minute, and oral temperature of 99° F. The heart, lung and abdominal examination were normal. The most prominent finding was a rash on both lower extremities covering the anterior pretibial surface and extending around the leg to the calf. The rash was hyperpigmented with flat, large, "stuck on" irregular scales. Ankle and pedal edema was also present. Clinically, this was "acquired ichthyosis" (Fig. 1).

A white blood cell count was 4,800/mm^3 with 35% lymphocytes and 10% eosinophils. Other studies included a calcium of 8.4 mg/dl, a total protein of 7.4 grams/dl (albumin, 3.0 grams/dl; globulin, 4.4 grams/dl), and a sedimentation rate of 18 mm/hour. A repeat HIV antibody test was positive for both p24 and gp41 antibodies. The T helper/suppressor cell ratio was 0.59 and the absolute T helper cell count was 329/mm^3. The chest roentgenogram (Fig. 2) revealed bilateral hilar

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adenopathy, confirmed by computerized tomography of the chest. A fiberoptic bronchoscopy with transbronchial biopsy demonstrated only a chronic inflammatory process without evidence of *P carinii*, mycobacteria or fungi. A skin biopsy (Fig. 3), in addition to showing epidermal changes of ichthyosis, revealed numerous noncaseating granulomas in the superficial and deep dermis. This extensive involvement of the dermis probably was responsible for the peripheral edema. A serum angiotensin converting enzyme was 175 units per liter (normal, 21-69). A mediastinoscopy with lymph node sampling was performed which demonstrated a noncaseating granulomatous lymphadenitis (Fig. 4) without evidence of an opportunistic lung infection or malignancy. Special stains and cultures of skin biopsy and mediastinal lymph nodes for bacteria, mycobacteria, and fungi were negative. The patient was treated with topical steroids and discharged. The rash improved and seven months after discharge he remained asymtomatic.

Fig. 2. Chest roentgenogram revealing bilateral hilar adenopathy.

Fig. 3. Skin biopsy with noncaseating granulomas in superficial and reticular dermis (H & E ×250).

Discussion

The differential diagnosis of symmetrical hilar adenopathy in most individuals includes sarcoidosis, tuberculosis, histoplasmosis, toxoplasmosis and lymphoma. Other less common causes of this roentgenographic presentation would include nonspecific inflammatory lymphadenitis, metastatic carcinoma, other fungal diseases, or mononucleosis secondary to cytomegalovirus or Ebstein-Barr virus. However, in patients infected with HIV, the differential diagnoses expands to include intrathoracic lymphoma, visceral Kaposi's sarcoma, typical and atypical mycobacterial infections, and disseminated cryptococcosis or histoplasmosis.

In some patients infection with HIV progresses to acquired immunodeficiency syndrome (AIDS), pre-

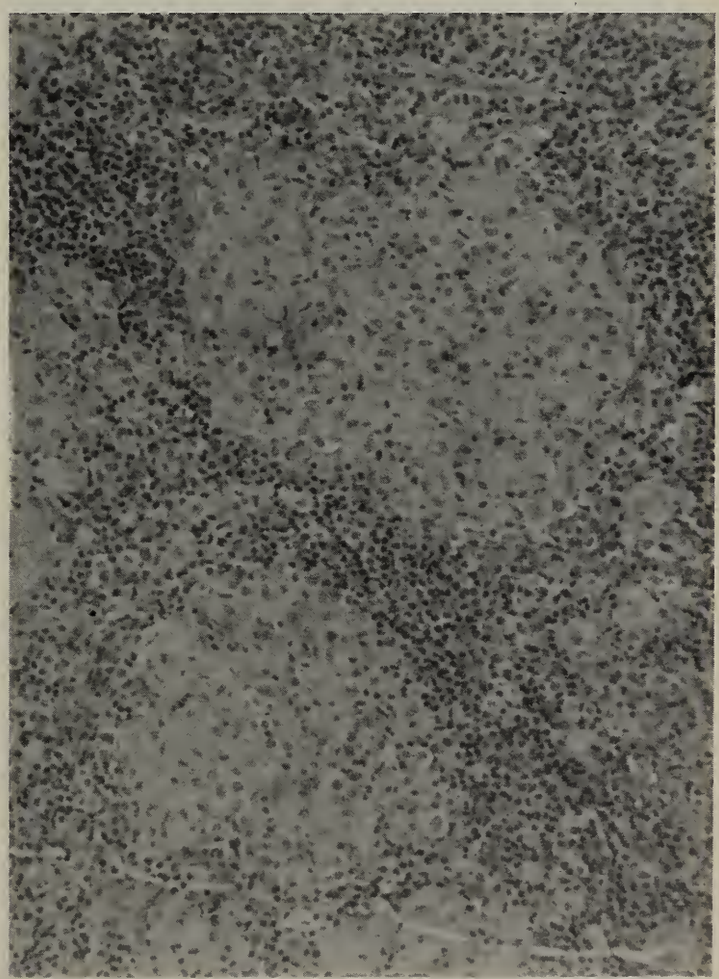

Fig. 4. Mediastinal lymph node biopsy with noncaseating granulomas (H & E ×250).

senting with severe infections such as *Pneumocystis carinii* pneumonia or disseminated atypical tuberculosis, while others present with diffuse malignancies such as Kaposi's sarcoma or intrathoracic or intracranial lymphomas. There is usually a prodrome of anorexia, weight loss, lymphadenopathy and a peripheral lymphopenia. In our patient the skin lesions initially were thought to represent a cutaneous manifestation of a thoracic tumor, either lymphoma or Kaposi's sarcoma. Only after the biopsies of the skin and lymph node were obtained was the diagnosis of sarcoidosis made.

Sarcoidosis, a multisystem disease, affects not only the lungs and the reticuloendothelial system, but also the eyes, skin and liver. Intrathoracic involvement is found in over 90% of patients and bilateral hilar adenopathy is the most frequent finding. Acquired ichthyosis is one of the many skin manifestations seen in sarcoidosis. The classic pathological finding in all affected tissues is noncaseating granulomatous inflammation.

In sarcoidosis, both T helper and suppressor lymphocyte counts are elevated in the peripheral blood.[3,4] However, the T helper lymphocytes are sequestered in areas of disease, attracting monocytes and macrophages, leading to the formation of the noncaseating granulomas. Cutaneous skin anergy from the excess T suppressor lymphocytes in the peripheral circulation and a polyclonal gammopathy are other manifestations of this disease.[5]

The immunologic abnormalities occurring in AIDS are well described.[6] Classically low levels of helper T cells and an inverted T helper to suppressor cell ratio are seen. As in sarcoidosis, a polyclonal hypergammaglobulinemia may be seen. Quantitated lymphocyte subsets in bronchoalveolar lavage lymphocytes may reveal a depressed T-4/T-8 ratio in AIDS patients while those with sarcoidosis generally have a preserved T-4/T-8 ratio.[4]

In one prior report,[5] AIDS developed in a patient who had had sarcoidosis ten years previously but was currently asymptomatic and not on corticosteroids. On presentation, that patient had the characteristic immunologic deficiencies noted with acquired immunodeficiency syndrome. In our patient, the peripheral T helper/suppressor ratio was depressed with a low normal absolute T helper cell count consistent with either HIV infection or sarcoidosis. However, the development of sarcoidosis would suggest that sufficient numbers of helper T cells and normal pathways of activation of monocytes and macrophages were present in order to initiate the formation of noncaseating granulomas within the skin as well as hilar lymph nodes.

A positive HIV antibody titer in an individual need not imply an immunodeficiency state. Indeed, common problems have been described in AIDS patients, such as pneumococcal pneumonia[7] and tuberculosis.[8] Hilar adenopathy in an HIV antibody positive patient may suggest an opportunistic infection and/or occult malignancy. Similarly, the skin lesions could easily have represented a cutaneous manifestation of either lymphoma or Kaposi's sarcoma or a disseminated fungal or mycobacterial infection. However, it must be recognized that other common problems such as sarcoidosis may be responsible for either finding. Therefore, a tissue diagnosis should be pursued, especially in view of the implications of treatment of sarcoid with corticosteroids, which can further alter immune function.[9]

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ABSTRACTS

These are abstracts from the scientific session of the Virginia Dermatological Society's annual meeting on November 6, 1988, in Williamsburg. Dr. James W. Patterson was moderator.

Fabry's Disease. Grace A. Newton, MD, Charlottesville.

A 35-year-old man first noted the development of skin lesions (angiokeratomas) at age 14. About one year later, he developed attacks of pain and paresthesias in his hands and feet, which over the years worsened in frequency and severity. The pain could be elicited by hard work or changes in temperature. Two maternal cousins had similar abnormalities. In July 1988 he was begun on amitryptyline with good control of pain crises and possible improvement in the associated hypohidrosis. Cutaneous examination revealed several deep red, 1–3 mm non-blanching macules clustered in the umbilical and genital regions. These findings indicated the diagnosis of Fabry's disease (galactosidase A deficiency), an X-linked recessive disorder. Other abnormalities can include myocardial ischemia, congestive heart failure, neurological signs and symptoms, and azotemia. Many of the changes are due to a deficiency of alpha-galactosidase A, which results in the accumulation of glycosphingolipids in lysosomes of various tissues. In addition to symptomatic management, treatment includes various means of enzyme replacement and substrate depletion. Amitryptyline was helpful in pain management in this case.

Linear IgA Bullous Dermatosis. Joy Gittin-Boyne, MD, Charlottesville.

A 54-year-old man presented with a generalized vesiculobullous eruption of three weeks' duration. Physical examination reveled generalized erythematous papules, tense bullae, and grouped herpetiform vesicles. Target-like lesions were present on the palms. Mucous membranes were spared. Biopsy showed a subepidermal blister with a predominance of neutrophils. Direct immunofluorescence showed linear deposits of IgA at the dermal-epidermal junction, and indirect immunofluorescence studies were negative. The findings confirmed the diagnosis of linear IgA bullous dermatosis. The patient was unresponsive to prednisone, but once the diagnosis was established he was placed on dapsone, which resulted in cessation of new blister formation. Linear IgA disease is considered by some to be a variant form of dermatitis herpetiformis, but others prefer to list it as a separate disease entity, since patients may have large, tense blisters, be HLA-B8 negative, and lack evidence for gluten sensitive enteropathy. Chronic bullous dermatosis of childhood also shows linear IgA deposits along the epidermal basement membrane, but unlike the adult disease, the childhood disorder shows predominantly perioral and perineal lesions and has a high spontaneous remission rate.

Graft Versus Host-Like Reaction Associated with 5-Fluorouracil Chemotherapy. Estelle Young, MD, and Donna Fukumoto, MD, Petersburg, and James W. Patterson, Richmond.

Three patients presented with Duke's D adenocarcinoma of the colon and a history of intravenous infusion chemotherapy with 5-fluorouracil. None had received blood products or had undergone bone marrow transplantation. Shortly after initiation of therapy, each patient noted a dusky erythema involving the palms and soles. Other findings encountered in varying degrees included sclerodactyly, flexion contractures, thinning of the nails, and white patches with lacy configurations on the buccal mucosae. Lesions seemed to persist despite reductions in dosage, although temporary discontinuation of therapy was accompanied by improvement in two cases. Biopsies of affected skin showed vacuolar degeneration of the basilar layer, sometimes accompanied by a band-like dermal lymphocytic infiltrate and accumulations of lymphocytes in lower portions of the epidermis. A distinctive acral erythema similar to that described here has been reported in association with cyclophosphamide, cytarabine and/or doxorubicin therapy, but because those patients had also received blood products or bone marrow transplants, it was unclear whether the changes represented drug reactions or graft versus host disease. The findings in our cases suggest that 5-fluorouracil chemotherapy alone may produce cutaneous changes closely mimicking graft versus host disease.

Exuberant Secondary Syphilis in a Patient with HIV Positivity. David M. Pariser, MD, Harry Pariser, MD, Robert Pariser, MD, and Ann Wry, Norfolk.

This case involves a 46-year-old homosexual man with HIV seropositivity and unusual manifestations of secondary syphilis. The patient presented with annular, nodular lesions that had elevated erythematous borders and central clearing with hyperpigmentation. The appearance resembled annular dermatitis or early mycosis fungoides. Nontreponemal (VDRL) test for syphilis showed reactivity with a titer of 1:256. A biopsy specimen was suggestive of secondary syphilis. The lesions cleared after the second intramuscular injection of 2.4 million units of benzathine penicillin. This case illustrates one of several recent cases of abnormal presentation of syphilis in an HIV-positive individual. Secondary syphilis usually manifests itself as a maculopapular erythematous rash involving the trunk and extremities including the palms and soles.

This rash usually follows a primary chancre of the genitalia or oral mucosa by 2–10 weeks. If untreated, tertiary syphilis may ensue, which may produce a vast array of clinical pictures, including that of annular, nodular, elevated erythematous lesions as were seen in this case. Our case suggests that HIV seropositivity may alter and/or accelerate the course of infection with *Treponema pallidum*.

Erythema Chronicum Migrans of Lyme Disease. Bonnie F. Straka, MD, Charlottesville.

A 21-year-old woman presented in the 19th week of her first pregnancy with a one-day history of an enlarging red lesion on her right thigh. The lesion began as a small red bump one day after playing with her dogs in tall grass in Aroda, Virginia. Other symptoms included headache, arthralgias, myalgias, and nausea. Physical examination revealed a 2 cm erythematous plaque with papular border and suggestion of central clearing on the right thigh. Five days later, the plaque had expanded to a three centimeter target-like lesion with two concentric rings, central clearing, and a distinct red border. Biopsy was consistent with a figurate erythema such as erythema chronicum migrans. A diagnosis of Lyme disease was made, and treatment was begun with penicillin VK 500 mg four times daily for 21 days. Lyme disease is transmitted by the bite of a tick, and the causative organism is a spirochete, *Borrelia burgdorferi*. It has been reported in a number of states in the United States, including Virginia. The disease may progress through three stages. Erythema chronicum migrans, the characteristic skin lesion, occurs in the first stage. The second stage features neurologic or cardiac involvement, and stage three is characterized by a monoarticular or oligoarticular arthritis. Early treatment with tetracycline or penicillin is effective.

Mild and Self-Limited Dominant Dystrophic Epidermolysis Bullosa. Robert J. Pariser, MD, Norfolk.

A newborn boy was seen in August 1987 because of congenital erosions. They were large, sharply defined, clean-based erosions located around the ankles. The right great toenail was partly detached. The family history supported an autosomal dominant transmission of the disorder. Erosions gradually healed with the use of moist dressings. Similar lesions occurred occasionally on the lower extremities for the first few months of life, but they gradually became less frequent. At 1 year of age, the child seemed to be developing no new blisters or erosions, and he was beginning to walk without problems. Several clinical variants have been described with features similar to Bart's syndrome, in which there is congenital absence of skin of the lower extremities along with trauma-induced blisters of skin or mucous membranes and nail changes. This case report indicates that the dominant dystrophic form of epidermolysis bullosa is one such variant and that it can have a relatively benign clinical course.

Exfoliative Erythroderma with Histologic Features of Erythema Multiforme. Allen D. Berry, MD, Beverly S. Darwin, MD, Eileen C. Kitces, MD, James W. Patterson, MD, and W. Kenneth Blaylock, MD, Richmond.

Five patients were recently encountered who presented with superficial exfoliative dermatitis but on biopsy showed typical changes of erythema multiforme. Clinically, each of the patients showed erythema with relatively superficial desquamation, while biopsy findings showed scattered necrotic keratinocytes, vacuolar degeneration of the basilar layer, and an upper dermal lymphocytic infiltrate, features characteristic of erythema multiforme. Treatments included topical and systemic corticosteroids and management of the underlying disorders, with variable results. Causes of exfoliative dermatitis include drug, lymphoma or leukemia, and a variety of primary skin disorders including atopic dermatitis, seborrheic dermatitis, psoriasis, lichen planus, and pityriasis rubra pilaris. A large number of cases are idiopathic. Biopsy usually shows either changes of dermatitis or specific features of the underlying dermatosis. Erythema multiforme typically produces papules, target lesions, bullae, or full thickness, sheet-like exfoliation of the epidermis (toxic epidermal necrolysis), but exfoliative dermatitis of the superficial type has not been described. Our results suggest that erythema multiforme should now be added to the list of dermatoses that can produce the clinical picture of exfoliative dermatitis.

Metastatic Eccrine Carcinoma (Malignant Acrospiroma). Ricardo G. Mora, MD, Norfolk.

Two patients are presented with forms of metastatic eccrine carcinoma. A 67-year-old man was referred for evaluation of a lesion of the left lateral eyebrow of six months duration. Examination also revealed a 1.0 cm cervical lymph node palpable in the left anterior triangle. CT scan of the orbit was unremarkable except for the soft tissue mass. Histopathology revealed a malignant eccrine acrospiroma with skeletal muscle invasion and lymphatic permeation. The patient underwent Mohs micrographic surgery and was referred to an otolaryngologist, where biopsy of the left neck node showed metastatic disease. At that point a left parotidectomy and left modified radical neck procedure were performed, followed by irradiation to the left temple, parotid bed, and left neck. There was no evidence of disease upon followup one year later. A 64-year-old man had developed a lesion on the left medial foot that upon surgical excision showed eccrine carcinoma. Six months later he was referred for evaluation of new lesions adjacent to the surgical scar. In addition to the skin lesions, physical examination revealed a fixed, enlarged lymph node in the left femoral triangle. The patient was referred to a surgical

oncologist for wide excision and lymphadenectomy, followed by irradiation to the groin and foot, and there was no evidence of disease upon followup at one year. Eccrine carcinomas are potentially aggressive tumors that are being encountered with increasing frequency. Mohs micrographic surgery in conjunction with other surgical approaches appears to be an effective means of managing these difficult tumors.

Transient Acantholytic Dermatosis. Cynthia Hall Dent, MD, Charlottesville.

A 79-year-old man had a three-week history of a pruritic eruption of the chest, back, and upper extremities. He reported having had a similar but less severe eruption one year previously which resolved after several weeks. Physical examination revealed numerous papulovesicular lesions on the chest, back and upper extremities with erythema and excoriations. The face was spared but revealed marked actinic damage and two basal cell carcinomas, one each on the nose and right earlobe. Biopsy confirmed the diagnosis of transient acantholytic dermatosis, and isotretinoin was begun at a dose of 40 mg daily. Transient acantholytic dermatosis is an acquired disorder usually encountered in older adults. Despite its designation as "transient," it can persist for several years. Microscopically, lesions show small foci of acantholysis that can have patterns mimicking those of Darier's disease, Hailey-Hailey disease, pemphigus vulgaris, pemphigus foliaceus, or spongiotic dermatitis. Isotretinoin has been reported to produce dramatic remissions in some patients with this disorder.

Subepidermal Bullous Dermatosis with Features of Epidermolysis Bullosa Acquisita. Chauncey A. McHargue, MD, Charlottesville.

A 37-year-old woman presented with a six month history of spontaneous noninflammatory bullous lesions limited to the hands and feet. They were modestly tender but otherwise asymptomatic and tended to run their course over several weeks, healing with superficial scarring. Medications included both replacement estrogen and iron. She did not use alcohol and there was no family history of similar disease. Physical examination confirmed the presence of nonerythematous vesicles and bullae on the dorsal and volar aspects of the hands and feet. Superficial scarring was present at the sites of previous lesions. Urine porphyrin studies showed slight elevations in uroporphyrin and coproporphyrin. Biopsy findings were consistent with epidermolysis bullosa acquisita or porphyria cutanea tarda, and direct immunofluorescence revealed a strong IgG band at the dermoepidermal junction and in vessel walls. However, immunofluorescent studies on salt-split skin preparations were negative. The differential diagnosis of noninflammatory subepidermal bullous eruptions is extensive and includes porphyria cutanea tarda and variants, epidermolysis bullosa acquisita, bullous drug eruptions, and bullosis diabeticorum. Direct and indirect immunofluorescence and porphyrin studies are useful in determining the correct diagnosis in these cases.

Aplasia Cutis Congenita. Audrey Gottlieb, MD, James W. Patterson, MD, and Allen D. Berry, MD, Richmond.

A dermatologic consultation was requested for a newborn infant with multiple cutaneous defects. The patient was the product of a full-term, otherwise uncomplicated, nonconsanguineous pregnancy. There was no family history of cutaneous disease. Upon physical examination, the newborn boy appeared to be healthy except for symmetrical, sharply marginated lesions on the trunk, back, thighs and scalp that showed complete absence of skin and subcutaneous tissue. Biopsy showed absence of epidermis and of cutaneous appendages in the underlying connective tissue. Unusual findings included bizarre vacuolated basal cells in the epidermis adjacent to an ulcer, and a dermal infiltrate that included numerous eosinophils. Affected sites have been granulating in well during treatment with Burows compresses and bacitracin ointment, and thus far no other developmental abnormalities have been noted. Aplasia cutis congenita is commonly recognized as a focal lesion on the scalp, and more extensive involvement such as reported here is unusual. Theories of development have included failure of neural tube closure (for scalp lesions), amniotic adhesions, or passage of thromboplastic material leading to placental and/or cutaneous infarctions. True congenital absence of skin can be distinguished from the junctional form of epidermolysis bullosa by clinical and microscopic studies.

VIRGINIA MEDICAL

EDITORIAL

Medical Practice Restriction

As Jimmy Durante was wont to say, "Everybody wants to get in on the act." Today it seems that everyone wants to be involved in the practice of medicine. Physicians are becoming accustomed, albeit not happily, to the self-serving paramedical groups, but there are others who would change the entire system. A recent report by the American Council on Science and Health[1] cites four such organizations:

- The National Health Federation (NHF) states that it promotes freedom of choice, but it really advocates questionable health methods. For NHF, no scientific proof of efficacy is necessary; marketing of an unproved treatment or product should not be restricted. This organization is very active in the political arena.
- The Health Alternatives Legal Foundation (HALF) claims to be a "non-profit public interest law center." Actually, it was founded to defend "alternative" health care practitioners and to initiate antitrust litigation challenging medical practice laws.
- The American Quack Organization (AQA) is a mutual support group of "holistic" practitioners. AQA strives to provide emotional support for its members by stimulating positive public feeling toward unorthodox practitioners.
- The Coalition for Alternatives in Nutrition and Health Care (CANAH) is primarily a lobbying effort. The main goal of this organization is enactment of a "Health Care Rights Amendment" which would allow any individual to choose and practice any desired type of health care.

Physician, beware. E.L.K., Jr.

1. Barrett S. The Unhealthy Alliance. New York, American Council on Science and Health, 1988

Addiction

Drug addiction is big news, big problem, and big money. You see it, read about it, hear about it. It's bad, dirty, destructive. It creates crime and destroys lives. It's big money. "Saying no" is not stopping the profit. The heads of governments, underlings, the CIA, law officers, rich men, poor men, doctors, lawyers, Indian chiefs are involved in this dirty, very profitable business.

The profits of the drug business buy people, planes, guns, tanks, bullets, lives. The enormity of the cash flow and profit makes money laundering a major problem. Losing a transport plane is ordinary overhead.

If you made $30,000 a year, is it conceivable that a $100,000 bribe might tempt you? $500,000? $1 million? While everyone may not have a price, I suspect that many of us do.

I propose that we make illegal drugs legal, which action will lower the price and deliver a death blow to the financial empire of the drug trade. At the same time we reenact prohibition, making all alcoholic beverages illegal. Obviously this is a variation of the fact that forbidden fruits are the sweetest, initially proved by the snake in the Garden of Eden.

These simultaneous actions will unleash American ingenuity and a new wave of illicit entrepreneurs, now to make and distribute alcoholic beverages. These people will be relatively poor and driven to establish their empires quickly before the drug trade can realign itself into alcohol.

Mom and Pop moonshine operations will develop into big business, pauperizing the Asian and South American drug kingdoms. Foreign competion will wither quickly. Made in America will no longer be just a slogan, but a reality.

At this point creative American legislative genius comes to the fore, but timing will be crucial. After

Alcohol Illegal Big Business (AIBB) drives out Drug Illegal Big Business (DIBB), we simultaneously make alcohol again legal and make tobacco illegal. An entire new wave of Mom and Pop operations, literally a grass root movement, replaces AIBB. Every little hidden valley will be green again. We may even see a resurgence of the mule and wagon in Tobaccoland, USA, since initially these nouveau riche will want to hide their sudden surge of wealth.

This great land of ours has innumerable addictive substances and activities. We can continue this illegalize/legalize ploy for decades without repetition. After drugs, alcohol and tobacco, we illegalize and later legalize chocolate candy, ice cream, nouvelle cuisine, Cajun cooking, professional wrestling, professional football and the Superbowl, soap operas, professional basketball, baseball, golf, tennis, sports cars, etc., etc. The list is literally endless.

Americans arise! Write your legislators now! They will never be this creative on their own.

H.S. Campell, MD

Hospital Notes

Sometimes a very unhappy experience can give insight. After spending many weeks with sick relatives in hospitals, I slowly began to realize why patients and their relatives can get out of sorts "for no obvious reason." The reason is simple: they are unhappy because they are extremely uncomfortable.

Have you sat for long in your waiting room chairs or in the hospital room chairs? Would you be caught dead with one in your house? Do you see these same Uncomfortable Chairs in the offices of the administrators, procurement officers or physicians? In their homes?

The Institute for Uncomfortable Chairs must be the design center for most chairs in hospital rooms, clinic waiting areas and physician's offices. Look at them carefully. Sit in one for an hour or two, and then try to walk without a limp, without a grimace of pain, without gently rubbing your buttocks.

Do any of these Uncomfortable Chairs look less than 100 years old? How do they make new chairs look so realistically worn before they leave the chair factory?

My research is valid and conclusive: You cannot be pleasant when your rear end is dead. If you doubt it, try it.

H. S. Campell, MD

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OBITUARY

• **Thomas Bowles Hedrick, MD,** general practitioner and former city councilman in Buena Vista; Medical College of Virginia, 1950; age 62; died December 28, 1988.

• **Margaret Allen Pennington, MD,** who before her retirement in 1984 practiced medicine in Buckingham County with her husband, William A. Pennington; Medical College of Virginia, 1937; age 79; died January 5 in Richmond after a lengthy illness. A gifted artist, Margaret Pennington recorded with pen and ink Buckingham County's architectural landmarks; many of these drawings were reproduced in VIRGINIA MEDICAL, and in 1977 they appeared in a book titled "The Courthouse Burned—."

• **Shockley DeWitt Gardner, MD,** former assistant state director of rural health who also had a private practice in Varina; Medical College of Virginia, 1930; age 84; died January 16.

• **Thomas G. Hardy, MD,** Columbus, Ohio, surgeon; Johns Hopkins University School of Medicine, 1950; age 61; died December 26, 1988.

Memoir of J.E. Gardner, Sr. 1903–1987

By Abraham Jacobson, MD

Dr. John Everette Gardner, Sr., age 84, passed away on September 7, 1987. He was born on April 9, 1903, in Hillsville, Virginia. He received his undergraduate degree from Roanoke College in 1925 and his MD from Johns Hopkins in 1928.

He interned at Jefferson Hospital from 1928 to 1929 and was an associate on the medical service from 1929–1931. He did postgraduate work in advanced cardiology at Massachusetts General Hospital, cardiovascular roentgenology at Temple University and internal medicine in London, England. He had staff appointments in internal medicine and cardiology at the former Jefferson Hospital (now Community Hospital of Roanoke Valley), at Lewis-Gale Hospital, and at Roanoke Memorial Hospital, where he was chief of cardiology from 1940–42, chairman of the electrocardiographic service and chief of medicine from 1950–51. He was certified by the American Board of Internal Medicine on October 31, 1946.

He served in the US Navy and Naval Reserve during World War II, attaining the rank of captain.

Dr. Gardner was a member of the American Thoracic Society, American College of Chest Physicians, American Medical Association, The Medical Society of Virginia, and the Roanoke Academy of Medicine, of which he was president in 1952–53.

His hobby was golf and he was a member of the Shenandoah Club and the Roanoke Country Club.

Dr. Gardner is survived by his wife, Nell S. Gardner, two sons, one stepdaughter and one stepson.

He deserves the highest praise for his loyalty, dedication, consideration and kindness to his patients throughout his practice.

Memoir of G. W. Atkinson 1931–1988

By Barry L. Katchinoff, MD, H. R. Howell, MD, and G. W. Johnson, MD

Dr. Gerald W. Atkinson died of a heart attack on March 20, 1988, at the age of 57.

Dr. Atkinson was born in Kingston, Tennessee, the son of a Methodist minister. He graduated from Lincoln Memorial University in 1952 and attended the Medical College of Virginia. Following an internship at DePaul Hospital in Norfolk he served in the US Army. After completing his military obligations he entered the private practice of family medicine in Jonesboro, Tennessee. He returned to Richmond in 1963 to enter the neurology residency program at the Medical College of Virginia and from 1966 onward was in the private practice of neurology in Richmond.

Dr. Atkinson served as the chief of neurology at Chippenham and Johnston-Willis Hospitals, where he was also medical director of the Special Procedures Laboratory. He also was president of the board of directors at the Richmond Headache Center.

His professional memberships included the American Medical Association, the Virginia Neurological Society, the Richmond Academy of Medicine, The Medical Society of Virginia, the National Association for Diagnosis and Treatment of Headaches, the Southern Medical Association, and the American EEG Society.

Jerry Atkinson was a gifted neurologist whose kindness and warmth touched his colleagues and patients alike. He provided a blend of professional competence and integrity that was admired by all. His personality was characterized by calm strength and quiet charm. He will be sorely missed by his family and friends.

He is survived by his wife, Joann, and four sons: Jonathan G. Atkinson and Timothy G. Atkinson of Richmond, Theodore J. Atkinson of Glen Allen, and S. Jeffrey Atkinson of Mechanicsville.

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LETTERS

Report angioedema secondary to hypertension medications

Enalopril is a relatively new angiotensin converting enzyme (ACE) inhibitor that has become increasingly popular as a first-line drug in the treatment of hypertension at the Medical College of Virginia/Virginia Commonwealth University. Captopril, another ACE inhibitor, is also used frequently in the treatment of hypertension. The authors report four cases of angioedema associated with the use of enalopril and two cases associated with the use of captopril between June 1986 and June 1988. One patient required an emergency tracheostomy for airway obstruction.

These six cases of angioedema represent 20% of all adult patients admitted to the Medical College of Virginia Hospitals with upper airway obstruction during this two-year period. Angioedema resulting from ACE inhibitors is unlikely to be mediated by IgE, therefore, the mainstay of therapy, such as epinephrine, antihistamines and steroids, may not be successful in the treatment of this complication. Surgical intervention may be needed in patients with airway obstruction secondary to ACE inhibitor medications.

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Research and rabid dogs concern former health commissioner

The following is an edited version of a letter sent earlier to committee members in the Virginia General Assembly in regard to a bill restricting the use of animals for research:

Dog pounds have been described by some as "havens for pets." Actually, dog pounds were established for the purpose of confining—or eliminating—unlicensed, loose, stray dogs.

When rabies became rampant, the licensure law was amended to require proof that the dog had been vaccinated against this disease. This requirement essentially eliminated rabies in all dogs except the unlicensed stray ones.

When it became evident that the unvaccinated animals were not only the main cause of rabies but also the major source of human bites by rabid animals, the push was on for their elimination. Of course, there were other reasons for eliminating stray dogs, for

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example, sheep-killing dogs. Dog wardens, game wardens, sheriffs and others cooperated in rounding up these neglected dogs, many of them hungry and wasted. Rabies in dogs has now been almost completely eliminated and is found chiefly in unvaccinated wild animals. However, it could return if we neglect prevention measures, and man's close association with dogs makes these requirements very important.

I was State Commissioner of Health from 1951 to 1976, and I gave the sponsor of the dog vaccination law my assistance. The State Health Department was given considerable responsibility for helping control rabies. By law we were required to assist with the treatment of those bitten by rabid animals and to provide shots free of charge if the patient demanded it.

One day in the late 1930s, 21 people on the streets of Abingdon, Virginia, were bitten by one rabid, stray dog. As the local health officer there at the time, I personally gave the series of rabies shots to all of them—one shot a day, every day, including Saturdays and Sundays.

Mack I. Shanholtz, MD

5912 Upham Drive
Richmond VA 23227

Dr. Shanholtz is chairman of the Legislative Relations Committee of the University of Virginia Medical Alumni Association.

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BOOKS

Hidden Illness in the White House, by Kenneth R. Crispell, MD, and Carlos F. Gomez, with foreword by Sen. Birch Bayh. Durham, North Carolina, Duke University Press, 1988, 267 pp, with footnotes and index.

Illness in the White House has been a well-visited topic over the past eight years, in large part the result of having a septuagenarian as President. The attempted assassination of President Reagan and the several illnesses that followed his next two terms have particularly heightened interest in the Twenty-Fifth Amendment to the United States Constitution. Passed after the Kennedy assassination, the Twenty-Fifth Amendment provides different mechanisms by which the Vice President replaces the President when the latter becomes ill and incapacitated. *Hidden Illness in the White House* is a new addition to the literature. One of its authors, Dr. Crispell, is emeritus professor of medicine and law at the University of Virginia; the other, Carlos Gomez, was a medical student when the book was written. Quite properly, they raise more questions than can be answered and leave the reader praying that the Pesident's physician is a person of strong character and practicality.

A disabled President, medically unable to function, can be replaced either voluntarily or involuntarily under the Twenty-Fifth Amendment.[1] Under Section Three of the Amendment, the President can declare his own temporary disability. The Vice President serves as Acting President until the President declares that he has regained his health. This procedure was followed—in a manner of speaking—when President Reagan had colon surgery in 1985. Mr. Reagan wrote the Congress that Mr. Bush would be acting in his stead while he was under general anesthesia. Mr. Reagan refused, however, to name Mr. Bush Acting President as the Amendment requires, asserting that the drafters of the Amendment did not intend its application to such "brief and temporary periods of incapacity."

The President can also be replaced without his consent. Section Four provides a procedure for the Vice President along with a majority of the Cabinet to declare the President incapacitated. The President has a right to contest that declaration, and if there is a conflict, the issue is settled by the Congress. While the matter is being decided (there are rigorous time constraints), the Vice President, upon vote of the majority of the Cabinet, can remain Acting President.

The President's personal physician is not an officer of state. While paid by the government for his services, he is the President's doctor with a confidential doctor-patient relationship that he is duty-bound to protect. Thus the dilemma: what if the President has a disabling disease but orders his personal doctor not to break the confidentiality of the relationship and divulge that fact? Where does this doctor's duty lie, to his patient or to the nation as a whole? If the question of the President's health is litigated in a Section Four congressional trial, can the President's doctor be compelled to break the privilege and testify?

The authors by historical discussion of White House medical secrets concerning actual or alleged presidential disabilities demonstrate that the White House physician in fact may have tremendous power to alter history by concealing medical data. They offer no current solutions for future abuses, however, other than the sensible suggestion that perhaps a President and his physician should work out in advance a protocol for disclosure of medical problems in the event they arise in the future. Of course, a protocol—and its authorization to break the patient privilege under certain circumstances—can always be revoked by a President sick but unwilling to yield power. Or the Congress can pass a law abolishing the privilege under certain defined circumstances. Yet it is clear that no matter what protocols or rules of law are in existence, the job of applying them to disclosure of the President's health problems will never be easy so long as some patient confidentiality exists. We can only hope that the President's doctor has the mature judgment and moral fiber to properly balance the rights of his patient against the rights of the nation when the time inevitably comes. For those who are concerned with this dilemma, the book is good reading.

JOHN D. GRAD

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[1] The first section of the Amendment clarifies that when the President vacates office by death, resignation or removal, the Vice President becomes President, not Acting President or some other position implying lack of full power of the President. The second section concerns the replacement of a Vice President when that office beomes vacant. This section was utilized in connection with the appointment of Gerald Ford after Spiro Agnew resigned, and then of Nelson Rockefeller, when Mr. Ford became President after Richard Nixon resigned in 1974.

The Injured Athlete, 2nd Edition, by Daniel N. Kulund, MD. Philadelphia, J. B. Lippincott Company, 1988, illustrated, 603 pp.

The first edition of this book, published in 1982, received widespread recognition as a sports medicine primer for all physicians. In this second edition the overall organization is unchanged, with excellent chapters on the role of the team physician, pre-

participation exam, medical problems of athletes and sports psychology. The strength of the book lies in the clear and thorough discussion of each injury. Diagnosis, prevention and treatment, including a complete guide to rehabilitation exercises, is presented. Significant improvements in this edition include a discussion of the principles and usage of electrical stimulation in rehabilitation and expansion of the chapter on low back pain. In addition, each chapter provides prescriptions for rehabilitation, including the use of rubber tubing and swimming pool exercises. The book's primary deficiency lies in the rudimentary presentation of surgical treatments of the shoulder and knee, especially in light of recent advances in the treatment of the anterior cruciate ligament. Isokinetic testing and its use in rehabilitative exercise are also cursorily presented.

The Injured Athlete presents the Virginia approach based on a respected group's experience with and interest in the care of athletes. This book makes an important contribution to the library of the primary care physician.

FRANK A. PETTRONE, MD
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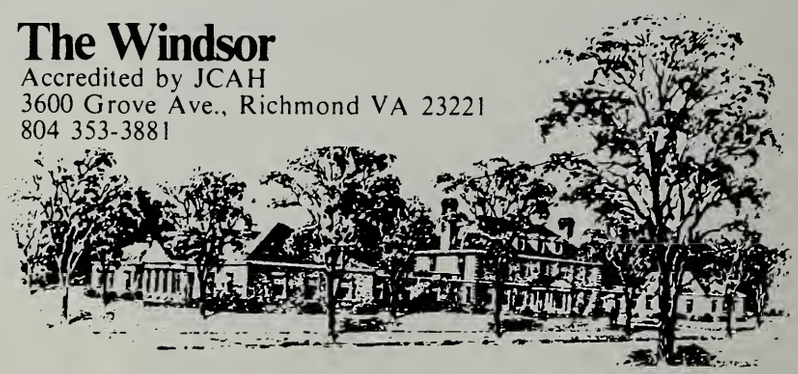

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VIRGINIA MEDICAL
APRIL 1989

Analgesics: The Physician's Partner in Effective Pain Management

Ada G. Rogers, RN, *New York, New York*

Effective management of pain depends on sufficient knowledge of the pharmacology of analgesics, careful assessment of each patient's pain, and a change of attitude toward the use of potent opioid (narcotic) analgesics. Utilizing extensive experience and the results of studies at Memorial Sloan-Kettering Cancer Center, the author rebuts physician misconceptions, recommends strategies for 25 medication problems, and provides oral/parenteral equivalencies of the most common analgesics.

Surveys have demonstrated that many patients suffer needlessly because of undermedication due largely to insufficient knowledge of the pharmacology of analgesics, the misconceptions and attitudes of health care providers towards the use of opioid (narcotic) analgesics, and the fear of drug abuse.

For the past 37 years controlled double blind crossover studies have been conducted at Memorial Sloan-Kettering Cancer Center to determine the relative potency of analgesics. More recently, studies also have involved the measurement of plasma levels in conjunction with the estimation of therapeutic and adverse effects. The results of these studies have provided information contributing to the better management of patients with postoperative and cancer pain. The suggestions in this paper are primarily based on the results of some of these studies and on our experience with the use of analgesics in postoperative and cancer pain.[1,2]

From the Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York NY 10021, where Ada Rogers is a research associate.

Our studies have shown consistently that there is considerable variation among patients in their responses to analgesics. It is not uncommon for some physicians to prescribe or recommend one drug or a set of a combination of drugs and expect every patient to respond favorably. When this proves unsuccessful, the patient is often labeled a chronic complainer, overreacting, or more often "addicted," even when there is evidence of organic disease. Patients are individuals. Even those patients with the same disease will respond in different ways. Each patient, therefore, should be carefully assessed. Some of the vital factors that need to be considered are presented in Table 1.

Eliminating Misconceptions and Myths

In the last decade a great effort has been made to identify problems in the management of pain. Many of the problems were linked to misconceptions and myths about the use of analgesics in patients. Defining certain characteristics or aspects of opioid analgesics and patients may help to eliminate some of these misconceptions and myths.

1. *Use of potent opioid analgesics will always lead to drug abuse*. The incidence of drug abuse when these

drugs are used legitimately is less than 1%. Once the pain is eradicated, most patients will discontinue the use of analgesics.

2. *Withholding opioid analgesics will prevent drug abuse.* It only compounds the problem. It takes twice as much medication to control severe pain. The longer the patient has to wait, the worse the patient will become.

3. *Tolerance and physician dependence are synonymous with drug abuse.* Tolerance is that characteristic which requires increasingly larger doses to provide the same effect as the original dose. Physical dependence is an altered physiological state produced by the repeated administration of a drug which necessitates its continuation to prevent the appearance of the stereotype withdrawal or abstinence syndrome characteristic of a particular drug. On the other hand, drug abuse or addiction is classified as a behavioral pattern of compulsive drug use characterized by overwhelming involvement with the use of the drug, the securing of its supply and a high tendency to relapse after withdrawal. It is possible to be physically dependent on drugs without being addicted (babies whose mothers are addicted are physically dependent at birth and will show signs of withdrawal) and to be addicted without being physically dependent (as with cocaine).[3]

4. *The patient who exhibits signs of withdrawal is "addicted".* When opioid analgesics are stopped abruptly in patients who have been receiving these drugs for several weeks, patients will exhibit signs of withdrawal. This does not imply drug abuse. These patients should be administered opioid analgesics on a tapering schedule.

5. *A positive reaction to a placebo is an indication that the pain is not real.* Studies have shown that the placebo effect results from the physician-patient relationship, the significance of the therapeutic effort to the patient, and the mental set imparted by the therapeutic setting and by the physician. These factors vary considerably from one patient to another and in any one patient at different times. A positive placebo response does not indicate that the patient's pain is not real; therefore, a placebo is not a reliable tool in the assessment of pain in clinical practice.[3]

6. *Patient behavior is a reliable instrument in the assessment of pain.* A patient's reaction to pain may vary as greatly as his or her response to analgesics. The patient with a flat affect who states that he/she has severe pain may not be believed. Conversely, the patient who moans, groans, grimaces, thrashes around and/or cries, in many instances may not be in pain. Unfortunately, our own attitudes and conceptions about pain may obscure or influence our assessment of the patient. In our studies the patient's reports of pain have been a reliable tool in the assessment of analgesics. Behavior alone is not a reliable measurement of pain or analgesic effectiveness.

7. *Sleep is an index of pain relief.* In our studies, patients are awakened to assess their pain and pain relief. It is not surprising to find that when awakened, the patients reported severe pain. Some patients are able to sleep even with severe pain. Others may sleep due to the sedative effect of different drugs.

Table 1. Pain Assessment Guide.

1. Status of Patient. a) Newly diagnosed? b) Recurrent or metastatic disease? c) Terminal?
2. Physiologic Factors. a) Organ dysfunction. b) Abnormal chemistries. c) Blood dyscrasia.
3. Other Signs and Symptoms. a) Dehydration. b) Nausea/vomiting. Diarrhea/constipation. d) Fever. e) Shortness of breath.
4. Age and Weight of Patient.
5. Pain Assessment. a) Onset of pain. b) Site and character. c) What makes pain worse or better? d) Why does patient think he has pain? e) Changes in mood because of pain or disease?
6. History of Prior Analgesics. a) Drug, dose, route, time intervals. b) Length of time on narcotics. c) Analgesic effectiveness—onset of action, duration/amount of relief. d) Adverse effects—allergies, sensitivities, sedation, constipation/other narcotic-like effects.
7. Other Drugs.

8. *Patients who watch the clock are "addicted".* The "clock-watcher" may be developing a tolerance. The first sign of tolerance is a shortening of the duration of analgesic effect. Patients not only watch the clock, but often request medication before it is due. Clock-watching is also a sign that the time intervals are too long.

9. *Visitors and family members make a patient's pain worse.* Some patients, especially the elderly, may not request or take opioid analgesics as often as they should. Many want to be known as "good" patients and they fear addiction. In these situations, the visitors or family members may request analgesics for the patient. This leads to the assumption that the patient's pain gets worse whenever the visitors or family members are present.

Prescribing Errors

The most common error made in the prescribing of opioid analgesics is the use of the same milligram dose regardless of the route of administration. Oral/parenteral ratios, peak, and duration of effect differ from one analgesic to another (Table 2).

Other errors include assuming that increasing the dose will always cause respiratory depression and sedation, that in young patients the need for larger doses or requesting medications more frequently is interpreted as a sign of abuse, and that difficulty in switching from parenteral to oral administration means that the patient "likes" injection and is therefore addicted.

Severe pain often acts as an antagonist to the respiratory and sedative effect of the opioid analgesics, thus increasing the dose should not produce respiratory depression or oversedation; however, in patients with severe organ dysfunction caution should be used, and opioid analgesics with long half-lives

Table 2. Equivalencies of the Most Common Analgesics.

The oral/parenteral efficacy ratio refers to the ratio of doses given by the two routes of administration necessary to produce equivalent "total" analgesic effect when both intensity and duration of effect are taken into account. If only maximal intensity or peak effect is considered, however, oral administration yields even less effective analgesia than parenteral administration. These studies were done on cancer patients. In other types of pain, equivalencies may not be the same.

Generic and/or (Trade) Name	Dose	Equivalent To	Peak Effect	Duration	Plasma Half-Life	Comments	Precautions
NON-NARCOTICS							
Acetaminophen (Tylenol, Tempra, etc.)	600 mg po 600 mg rectal sup	Aspirin 600 mg	2 hrs Slower than oral	3–4 hrs	1–4 hrs	Antipyretic and antiinflammatory action is weak	In large doses, may cause liver toxicity
Acetylsalicylic acid (aspirin)	600 mg po	Morphine 2 mg IM	2 hrs	3–4 hrs	15 min	Has antipyretic and anti-inflammatory activity	Used with steroids, it may increase gastric bleeding
Choline magnesium trisalicylate (Trilisate)	1500 mg bid 600 mg rectal sup	Unknown	1–2 hrs Slower than oral	12–24 hrs	9–17 hrs	Does not affect platelet aggregation; may benefit bony metastasis	Use with caution in patients with renal insufficiency or with peptic ulcer, active gastritis
Methotrimeprazine (Levoprome)	20 mg IM	Morphine 10 mg IM	1 hr 30 min	4–6 hrs	Unknown	A phenothiazine; recommend starting with 5 mg dose	May cause oversedation, orthostatic hypotension, liver toxicity
NARCOTIC ANTAGONISTS							
Buprenorphine HCI (Buprenex)	0.3 mg IM 0.3 mg IV	Morphine 10 mg IM Morphine 10 mg IV	1 hr 30 min	4–5 hrs 3–4 hrs	2–3 hrs 2–3 hrs	Mixed agonist-antagonist; no psychotomimetic effect	May cause abstinence reaction in patients physically dependent on narcotics
Butorphanol tartrate (Stadol)	2 mg IM 2 mg IV	Morphine 10 mg IM	1 hr 30 min	3–4 hrs 3–4 hrs	2.7 hrs	Mixed agonist-antagonist; may produce psychotomimetic effect	May cause abstinence reaction in patients physically dependent on narcotics
Nalbuphine HCI (Nubain)	10 mg IM 10 mg IV	Morphine 10 mg IM Pentazocine 60 mg IM	1 hr 30 min	4–5 hrs 3–4 hrs	5 hrs	Mixed agonist-antagonist but less psychotomimetic effect than pentazocine	Same precautions as with butorphanol
Pentazocine HCI (Talwin)	60 mg IM 30 mg po 180 mg po	Morphine 10 mg IM Aspirin 600 mg Morphine 10 mg IM Pentazocine 60 mg IM	1 hr 2 hrs	3–4 hrs 3–4 hrs	2–3 hrs 2–3 hrs	Mixed agonist-antagonist may cause psychotomimetic side effects	Same precautions as with butorphanol; use with caution in patients with cardiac abnormalities

NARCOTICS

Codeine sulfate	30–60 mg po 200 mg po	Aspirin 600 mg Morphine 10 mg IM Codeine 120 mg IM	2 hrs	3–4 hrs	2½–3 hrs	Same as morphine, but weaker	Not for IV use
Hydromorphone HCl (Dilaudid)	7.5 mg po 3 mg rectal sup	Morphine 10 mg IM	1 hr	3–4 hrs	2–3 hrs	Quick onset of action. Available as high potency solution 10 mg/ml for tolerant patients	Same precautions as with morphine
	1.5 mg IM 1 mg IV	Morphine 10 mg IM	30 min 15 min	3 hrs 2–3 hrs	2–3 hrs	Has similar time effect as heroin; highly soluble	Same precautions as with morphine
Levorphanol tartrate (Levo-Dromoran)	4 mg po	Morphine 10 mg IM Levorphanol 2 mg IM	2 hrs	4–5 hrs	15 hrs	Same as morphine	Same precautions as with morphine
	2 mg IM 1 mg IV	Morphine 10 mg IM	1 hr 15–30 min	4–5 hrs 3–4 hrs			
Meperidine HCl (Demerol, Pethadol)	50 mg po 300 mg po	Aspirin 600 mg Morphine 10 mg IM Meperidine 75 mg IM	2 hrs	3–4 hrs	3 hrs	Causes CNS excitation ranging from irritability to seizures	Not for chronic administration in patients with renal dysfunction
	75 mg IM 50 mg IV	Morphine 10 mg IM	1 hr 5–15 min	2–4 hrs 2–3 hrs			
Methadone HCl	20 mg po	Morphine 10 mg IM Methadone 10 mg IM	2 hrs	4–5 hrs	15–22 hrs	Same as morphine	Same precaution as with morphine
	10 mg IM 5 mg IV	Morphine 10 mg IM	1 hr 15–30 min	4–5 hrs 3–4 hrs			
Morphine sulfate	60 mg po 10 mg 5 mg IV	Morphine 10 mg IM	2 hrs 1 hr 15–30 min	4–5 hrs 4–5 hrs 2–4 hrs	2½–3 hrs	May cause oversedation confusion, visual disturbances, urinary retention	Contraindicated in patients with impaired ventilation, asthma, elevated intracranial pressure, liver failure
(Roxanol SR, MS Contin controlled release tablets)	30 mg 60 mg	120 mg po bid equivalent to 40 mg q4h immediate-release morphine	4–5 hrs	8–12 hrs	2–3 hrs	Plasma profiles for these preparations will differ from immediate release, but elimination half-life is the same	Controlled release tablets should not be broken, crushed or chewed
(RMS)	5 mg 10 mg 20 mg 30 mg rectal sup	Not applicable	2 hrs	4–5 hrs	2–3 hrs	Plasma concentrations similar to immediate release oral morphine. Duration equal to immediate release oral morphine.	Rectal suppositories should not be used in patients with anal/rectal problems or low platelets
Oxycodone (with aspirin-Percodan; with acetaminophen-Percocet)	5 mg po 30 mg po	Codeine 60 mg po Morphine 10 mg IM	1 hr	3–4 hrs	2–3 hrs	Not available in IM or IV form	
Oxymorphone HCl (Numorphan)	1 mg IM .5 mg IV	Morphine 10 mg IM	1 hr 15–30 min	4–5 hrs 3–4 hrs	Unknown	Highly soluble; not available orally	Same precautions as with morphine
	10 mg rectal sup	Morphine 10 mg IM Oxymorphone 1 mg IM	2 hrs	6 hrs			
Propoxyphene HCl (Darvon, Dolene)	65 mg po	Aspirin 600 mg	2 hrs	3–4 hrs	12 hrs	A "weak" narcotic; structurally related to methadone	Overdose can be complicated by convulsions
Propoxyphene napsylate (Darvon N)	100 mg po	Aspirin 600 mg	2 hrs	2–4 hrs	12 hrs		

should be avoided. In patients who have become tolerant, tolerance develops at a different rate to the central nervous system effects. It is relatively rapid to the analgesic, respiratory and sedative effects; slower to the gastrointestinal, sphincter and miotic effects. Patients can be very tolerant but still complain of constipation. All patients on these drugs routinely should be on a bowel regimen to avoid constipation.

Concerning younger patients, pharmacological studies have shown that patients under 40 years of age eliminate opioid analgesics more rapidly than older patients. Duration of analgesia is shorter and these patients require medication at more frequent intervals.[4] Increasing the dose will provide longer duration of analgesic effect.

Through experience, patients soon learn that parenteral analgesics provide quicker and, in many cases, better relief. Oral analgesics have a slower onset of action and peak later than parenteral. Unless an equianalgesic dose is prescribed, the relief is less. One can easily understand why patients would prefer injections when the oral dose given is the same in milligrams as the parenteral dose, for example, meperidine (Demerol®) 75 mg intramuscularly is equivalent to 300 mg orally.[5] The usual doses prescribed orally are 50–100 mg.

Recommended Strategies for 25 Problems

About 80% of the pain consultations requested at Memorial Sloan-Kettering Cancer Center are primarily for analgesic adjustments. They tend to fall into the categories specified below.

1. Inadequate Relief of Postoperative/Chronic Pain

Problem	*Strategy*
• Less than 50% relief, patient taking medication infrequently.	Change order from PRN to ATC.
• Relief for only 2 hrs, patient taking medication but order is for every 4 hrs.	Change order to every 3 hrs. If still inadequate, and fever curve not being watched, add acetaminophen or aspirin. Antipyretics and narcotics work on different mechanisms, and the effect is additive. (Do not add acetaminophen if patient is receiving it in combination drugs).
• Relief for only 2 hrs, patient on short acting narcotic.	Change to longer-acting narcotic.
• Relief for only 2 hrs, patient becoming tolerant to narcotics.	Increase dose until adequate relief is obtained.
• Patient tolerant to narcotics, high doses give only slight relief.	Cross tolerance to narcotics is not complete. Switch, but decrease to 50% of equivalent dose of an opioid analgesic with short half-life.
• Patient tolerant to narcotics, narcotic with short half-life gives inadequate relief.	Switch to narcotic with longer half-life (e.g., methadone or levorphanol) but decrease equivalent dose by 75–80%. Give PRN for 72 hrs.[6]
• Medication takes too long to work.	If patient is already receiving medication around the clock plus antipyretics, choose narcotic with quicker onset of action.
• Patient has incident pain, increase in oral narcotic caused oversedation.	Use enough oral narcotic to control pain at rest. Supplement with 50–75% of equivalent intramuscular dose or 25–40% of equivalent intravenous dose.[7]

2. Adverse Effects

• Patient is oversedated, confused, disoriented, and on long-acting narcotic (70 yr, has liver/lung/brain involvement, elevated calcium).	Change to shorter acting narcotic or decrease dose and increase intervals. Avoid acetaminophen in liver disease.
• Patient on meperidine (Demerol®) is tremulous, has myoclonus jerking. BUN and creatinine elevated.	Discontinue meperidine. Its repeated administration in patients with compromised renal function may lead to accumulation of metabolite normeperidine, causing toxic effects ranging from irritability to seizures. Can also occur in long-term use of meperidine without renal dysfunction.[8] Do not give naloxone (Narcan®); it may lower seizure threshold.
• Pentazocine (Talwin®) produces psychotomimetic effects, patient allergic to all narcotics, on nothing by mouth.	Nalbuphine (Nubain®), a narcotic antagonist, has less psychotomimetic effect. Reportedly, buprenorphine (Buprenex®), a new narcotic antagonist, has esentially no psychotomimetic effect (Table 2).[9] Only non-narcotic parenteral analgesic available is methotrameprazine (Levoprome®), a phenothiazine analgesic, which may produce high incidence of sedation and orthostatic hypotension. Starting dose 5 mg.

3. Switching from One Route to Another

• Patient on IM narcotics for several weeks. Each attempt to switch to orals has failed. Orders written for meperidine 50 mg IM or po q4h PRN.	Meperidine 50 mg orally only 25% as potent as parenteral and equivalent to 2 aspirin. Switch to Percocet®, 2 tablets every 3 hrs (equivalent to at least 50 mg of meperidine IM and has quicker onset of action). See Table 2.
• Patient formerly on hydromerphone (Dilaudid®) 8	Intramuscular equivalent of 8 mg of hydromorphone is

Problem	*Strategy*
mg by mouth is now on nothing by mouth. Was given hydromorphone 8 mg IM and became oversedated, with respiratory depression.	approximately 1.5 mg. Patient received too large a dose.[10]
• Patient is vomiting and unable to swallow, cannot take oral analgesics, platelets are only 30,000, IM injection or rectal suppositories contraindicated, only route available is intravenous. Patient has been on levorphanol (Levo-Dromoran®) 2 mg IM q4h PRN with adequate relief.	Although the equivalent dose of intramuscular vs intravenous narcotics is not really known, it is advisable to start with half of the intramuscular dose, titrating up or down as needed; however, the time interval in IV administration should be shorter.
• Patient on levorphanol 3 mg IM every 3 hrs was switched to 6 mg orally but complains takes too long to work and refuses it.	Appropriate amount of levorphanol ordered, but there is difference between peak effect of oral and IM narcotics. Peak IM effect usually 1 hr, oral 2 hrs. More effective way to switch: decrease intramuscular gradually, increase oral when necessary. Can also be done when switching from intravenous to oral.
• Patient on IV morphine, relief for only 2 hrs, can take oral drugs.	Patients that can take oral drugs should not be switched to IV administration prematurely. Give instant release oral tablets (Table 2).
4. Switching to Controlled Release Morphine	
• Patient is taking immediate release morphine tablets 60 mg q4h ATC with adequate relief but prefers medication less often, especially during night.	Switch to controlled release morphine by doubling the dose (120 mg) q8h ATC. Supplement dose of immediate release morphine 30 mg should be prescribed q2h PRN. If the patient needs supplement dose at least 4 times in 24 hours, increase dose of controlled release morphine by 30 mg. Continue supplement dose as above.
5. Discharge Medications	
• Patient has difficulty swallowing, is sore from taking IM or subcutaneous injection.	Rectal suppositories are advisable, e.g., oxymorphone 10 mg q6h, equivalent to morphine 10 mg IM. (Oxymorphone rectal suppositories now available only in 5 mg dose).
• Patient is terminal, wants to go home, is unable to take oral analgesics, has colostomy. Must be sent home on injections of morphine.	Teach family member to give injections. Correctly taught and capability verified, there should be no problem. Another method: continuous subcutaneous infusion, using home care program and Cormed pump. Dose per hour calculated by taking the patient's prior 24 hour narcotic intake and dividing by 24.[11]
6. Withdrawal Syndrome	
• Patient on narcotics several months, pain eliminated, stops all narcotics abruptly, after 24 hrs becomes nervous, shaky, complains of sweats, cramping abdominal pain, diarrhea.	Patient dependent on narcotics, must be tapered off. It takes one-quarter of original dose to suppress abstinence reaction. Use narcotic with long plasma half-life and place patient on schedule. Example: patient on morphine 15 mg IM every 3 hrs, in 24 hrs has received 120 mg, equivalent to 240 mg oral methadone. One-quarter of 240 mg is 60 mg. Give 15 mg oral methadone every 6 hrs for 2 days. Decrease to 10 mg every 6 hrs for 2 days; then 10 mg every 8 hrs for 2 days; then 10 mg every 12 hrs for 2 days. Next, decrease to 5 mg every 12 hrs for 2 days; than 5 mg once a day for 2 days.
• Patient on morphine 10 mg every 3 hrs for one month may be becoming addicted. Pentazocine 45 mg IM substituted. Patient becomes diaphoretic, is shaking, crying and has goose flesh; respirations and pulse increased; pupils dilated.	Patients who have become physically dependent on narcotics have signs of withdrawal if narcotic antagonist is administered. Caution should be used when an antagonist is given to reverse overdose of narcotics. Smaller doses usually sufficient, but watch patient for reappearance of narcotic overdose.
7. Use of Adjuvant Drugs	
• Patient becoming very tolerant to narcotics, taking hydromorphone (Dilaudid®) 24 mg orally every 3 hrs. Longer acting narcotics cause too much sedation and disorientation.	Since there is no cross tolerance to nonnarcotic analgesics and tolerance does not develop in this class of drugs, add a nonnarcotic analgesic. (This does not mean a non*scheduled* drug, which may or may not be nonnarcotic.) The addition of a nonsteroidal antiinflammatory drug (NSAID) such as ibuprofen 400-600 mg per dose may achieve greater analgesia with less undesirable effects and may make it possible to decrease the narcotic dose. NSAIDS do not substitute for a narcotic; patients physically dependent on them should be gradually tapered before attempting to use NSAIDS alone.

Problem	*Strategy*
	NSAIDS should be used with caution in patients with bladder infections, kidney dysfunction, blood dyscrasia, or receiving chemotherapy (steroids) and radiation therapy. Prostaglandin synthesis may reduce bone pain and may sometimes slow down the progression of bone metastasis. The relative potency of the NSAIDS has not yet been established.
• Patient depressed, inadequate control of pain causing anxiety, given oral diazepam (Valium®) 5 mg 4 times a day, Patient becomes too sedated, crying, and still complaining of pain.	Diazepam increases depression, and in conjunction with narcotics, causes increase in sedation plus confusion and disorientation. Studies of some tranquilizers have not shown potentiation of the analgesic effects of opiates. Hydroxyzine (Vistaril®) 100 mg IM has some analgesic properties and in conjunction with morphine increases the amount of analgesia.[12] The effect is additive. Patients who are depressed should be given antidepressants rather than tranquilizers. Amitriptyline (Elavil®), starting with 25 mg orally at bedtime, is useful as an hypnotic as well. Amitriptyline also can reduce phantom limb pain; in most cases 25 mg orally at bedtime is sufficient.
• Patient becomes sedated on all narcotics, decreasing dosage insufficient to control pain.	A small dose (2.5 mg) of oral dextroamphetamine (Dexedrine®) will counteract the sedative effects of narcotics. Give one dose in the morning and, if necessary, a second in the early afternoon. Given later, it may cause insomnia.
8. Around-the-Clock vs On Demand	
• Patient receiving radiation therapy on Levo-Dromoran® 4 mg orally q4h ATC is oversedated and breathing 4 a minute.	ATC administration should not be used when dose and time intervals are being estimated, when adverse effects are being assessed, when ATC schedule produces adverse effects, or when patients are receiving definitive therapies.

Conclusion

In conclusion, the availability of a wide variety of analgesics and doses (opioid analgesics do not have ceiling effects) and the appropriate use of the different routes of administration offer each clinician the opportunity to achieve maximal relief with minimal undesirable effects in each patient. It is our responsibility to provide every patient with adequate relief of pain regardless of the cause.

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Patient-Controlled Analgesia

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Effective control of pain in the hospitalized patient is a challenge for all members of the health care team. Pain continues to be undertreated in the hospital setting for several reasons. Physicians prescribe doses which may be inadequate to effectively manage pain; nurses undermedicate because of concern about untoward effects of analgesics;[1–3] fear of drug dependency adds to the underutilization of opiate analgesics.[4] Delays in the process of drug administration also contribute to inadequate pain relief. Even when optimal doses are prescribed, the use of the "as needed" or PRN schedule of medication administration may lead the nurse to choose the lowest dose or longest interval available, thus perpetuating the undertreatment of treatable pain[5] (Fig.1).

Patient-controlled analgesia (PCA) bypasses the delays inherent in the traditional method of drug delivery. The patient activates an infusion pump with a sophisticated sequencing device. By pushing a button, the prescribed dose of pain medication is released into the intravenous line. An adjustable "lockout interval" controls the frequency of dose administration by preventing another dose from being delivered for a prescribed time period following each dose. The patient pushes the button in response to pain or in anticipation of pain, as with postoperative ambulation or wound care.

Morphine sulfate is the opiate analgesic most often used for PCA. Morphine is a short-acting narcotic analgesic and has no active metabolites which could cause problems in the elderly or those with renal dysfunction as does meperdine. Few complications have been reported using morphine and PCA. The drug has been found to be very effective, while lacking some of the adverse effects associated with other narcotic analgesics.[4,5,7,8]

The total amount of narcotic analgesic utilized via the PCA device is approximately equal to every 4–6 hour intramuscular dosing. However, intramuscular injections cause significant fluctuation in the amount of drug available at any one time, leading to a cycle of intense pain followed by sedation (Fig. 2). PCA maintains more constant and effective plasma levels of narcotic analgesic which the patient titrates to his/her individual need.[5] Problems reported with PCA have been primarily related to operator error in programming the device.[8]

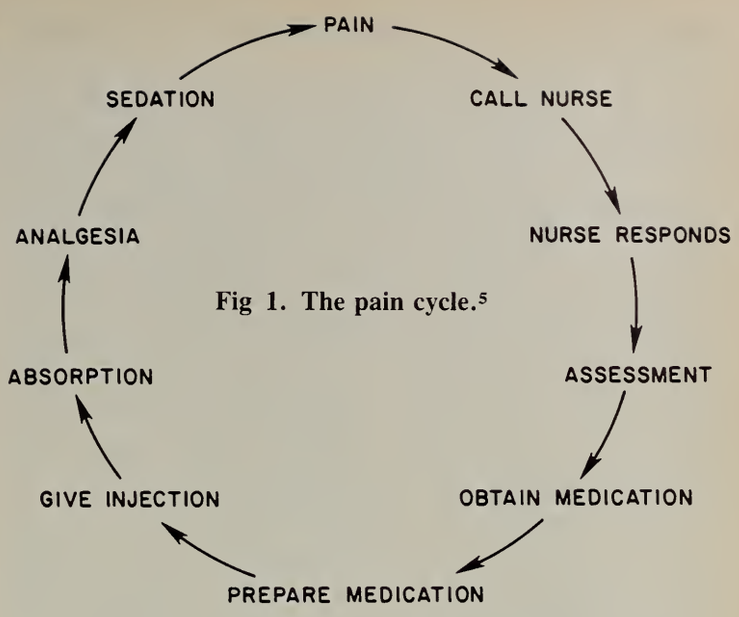

Fig 1. The pain cycle.[5]

Patient Selection

Patient populations appropriate for PCA are varied. Adult patients recovering from orthopedic, abdominal or other major surgical procedures[5,6] are an ideal population. One report of postoperative PCA use in adolescents, 11–18 years old, suggests that this age group may be appropriate when careful patient selection, preoperative instruction and close, postoperative monitoring is performed.[9] The pain crisis associated with sickle cell disease has also been successfully treated with PCA.[10] Chronic cancer pain can also be relieved with PCA, both in the hospital and in the outpatient setting.[11]

Because the active participation of the patient is needed for PCA to be effective, patient comprehension of the PCA concept is essential. Preoperative instruction is strongly recommended to ensure full comprehension and interest in using PCA.

Summary of Experience

Since the introduction of PCA into the Medical College of Virginia Hospitals setting in 1985, over 300

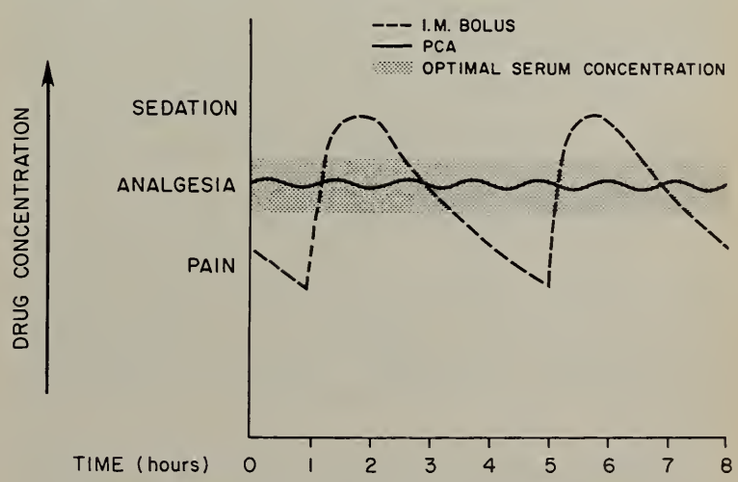

Fig 2. PCA versus bolus medication schedule.[5]

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patients have used PCA to successfully control postoperative or chronic pain.

To ensure the safe introduction of PCA into MCVH, it was essential that physicians, nursing and pharmacy coordinate efforts. Complete understanding of the device by nursing has reduced the possibility of operator error. Nursing also has developed systems to ensure that adequate patient monitoring occurs through regular pain and sedation assessment. Pharmacists have developed systems to store, distribute and maintain the device and drugs, as well as provide therapeutic consultation. Systematic introduction of PCA into clinical areas only after these supporting systems were in place has ensured its safe use.

Doses of morphine via the PCA device vary, but the common starting dose for postoperative pain is 1 mg with a "lockout interval" of 6 minutes. Some devices have an additional 4-hour limit, which is usually set at 20–25 mg. Individual dosing regimens for beginning PCA are based on patient age and general physical condition. The patient's perception of how well pain is controlled is the primary consideration for dose alterations. The PCA dose is usually increased or decreased by 50%, although few patients require dose adjustments. The lockout interval can also be adjusted to lengthen or shorten the period of inaccessibility to the drug. New PCA technology now offers devices with combination delivery systems of PCA plus continuous infusion.

The continuous or basal rate is calculated based on the analgesic need over a 24-hour period. A PCA or bolus dose is made available as frequently as the physician desires in order to allow the patient additional medication at times when breakthrough pain occurs. Using the PCA dose before and during activity or in conjunction with wound care are common examples of the need for additional doses. For the management of both acute and chronic pain, this combination broadens the options available for patients.

Patient response to PCA is consistently favorable. Those patients who have experienced prior surgery without PCA note that the postoperative course with PCA is less painful. They report fewer periods of intense pain followed by sleep or drowsiness. Early ambulation also seems to be encouraged by PCA use. Lastly, patients perceive the feeling of having control as a positive one. They prefer not being dependent on someone else for the provision of their pain medication.

The MCVH experience has included few problems. One patient became oversedated, necessitating removal of PCA. The cause was unclear, but may have been either machine malfunction or an idiosyncratic drug reaction. Occasionally, patients are hesitant to push the button and need encouragement and reassurance.

Although postoperative pain is the most common indication for PCA at Medical College of Virginia Hospitals, the experience with PCA in chronic cancer pain is growing. Patient-controlled analgesia is being used in conjunction with a fixed, scheduled, oral narcotic to control breakthrough pain. After 24–48 hours, the total parenteral and oral narcotic need can be calculated and the oral dose adjusted more accurately. Sickle cell crisis pain is also being well controlled with PCA and in combination with either oral narcotics or continuous infusion. Patient-controlled analgesia is not restricted to the inhospital setting. Small, compact ambulatory devices now allow patients to use this modality at home. Either the subcutaneous or intravenous route is being regularly used to control chronic cancer pain. Usually a basal rate of 1–2 mg/hr is used with a PCA dose of 1–2 mg for breakthrough pain. These doses are then titrated to patient comfort.

Conclusion

The PCA system of analgesic delivery provides excellent pain relief for patients experiencing acute and chronic pain. Introduction of this system into the hospital setting requires collaboration among all members of the health care team to ensure safety and maximum efficacy.

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Neurosurgical Concepts of Pain Control

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Pain is a necessary ingredient for survival. Like other complex functions important for survival, pain exhibits many states of order and disorder. The anatomy and physiology of pain is akin to the physiology of the coagulation of blood or respiration of cells. Like all complex systems associated with survival, pain syndromes represent major clusters of disease entities when "normal" patterns are disrupted. There must be a disturbance in pain-associated neurophysiology or metabolism, local or distributed, which contributes to the pathological state.

Neurosurgeons have finally learned that destructive lesions of the central nervous system commonly fail to relieve pain for long periods of time. This observation has led to the use of nondestructive electrical stimulation in humans and has provided an important source of new information about the organization of pain pathways in humans. Of course, most important of all has been the development of techniques from molecular biology and immunochemistry, coupled with the discovery of compounds that influence the brain's response to pain. As outlined below, discovery of these compounds has enhanced our knowledge of pain and pain control.

Neuropharmacology is the study of how drugs and other chemicals affect brain function. Over the past 15 years, neuropharmacologists have made remarkable advances in our understanding of how the brain encodes information about pain and how analgesics such as morphine can reduce painful sensations. Two important observations have revolutionized our understanding of how morphine abolishes pain. First, researchers in the mid-1970s discovered that the brain contains its own endogenous morphine-like substances. In addition, the brain contains specialized proteins called receptors, which allow the brain's own morphine to produce specific effects, such as reduction of painful sensations. The second set of observations[1] was that morphine does not produce analgesia by blocking nerve function like a local anesthetic. Rather, morphine excites or activates specific brain regions which ultimately inhibit pain input at the level of the spinal cord. These two sets of observations have had a profound influence on the management of pain syndromes.

Neuropharmacologists have also made important advances in our understanding of how pain may be reduced by nonopiate systems. These studies of nonopiate analgesia, pioneered by Dr. Ronald L. Hayes at the Medical College of Virginia,[2] emphasized that the brain contains a number of different mechanisms that can control pain but do not involve endogenous morphine-like substances. While the precise chemical mechanism mediating this kind of pain relief remains to be described completely, studies have suggested that the brain chemical, acetylcholine, is very important in pain control. In fact, this line of research has led to the discovery of new brain sites which, when stimulated electrically, may also produce pain relief in humans. Future research in the area of nonopiate pain control holds great promise for new therapies in treating patients. Importantly, nonopiate procedures for pain control may not have the same liabilities seen with opiates, such as tolerance and addiction.

While great strides have been made in understanding mechanisms of analgesia, important though less dramatic advances have been made in our understanding of the neuropharmacology of pain transmission. Identifying which brain chemicals are responsible for transmitting information about pain is critical to our developing additional strategies for blocking pain input. A brain chemical or peptide called substance P has been known for over 50 years. A role for substance P in transmission of sensory information was suggested even in the 1950s. However, the majority of evidence that this compound is involved in pain transmission has accumulated over the last decade. Substance P meets several of the criteria required to be considered as a possible transmitter for pain. It is found in many nerves that transmit information from the skin surface to the spinal cord. It has been shown to be released in the spinal cord by painful stimulation. This release excites spinal cord neurons involved in pain transmission and can be blocked by opiates. Thus, many investigators feel that Substance P indeed serves as a transmitter for information from the skin about painful sensations. However, its role has become very controversial for the following reasons. First, the excitatory action of substance P is very long-lasting, much more characteristic of a modulator of neurons than a chemical involved in transmission of specific information. Second, studies in which substance P has been eliminated from nerves fails to block thermal and mechanical pain, at least in the cornea. Third, the behavior elicited by direct administration of substance P into the spinal cord does not seem to be related to pain but rather to convulsive-like activation of spinal cord motor neurons. Other investigators are examining the role of excitatory amino acids, such as glutamate. The excitatory action of glutamate on brain cells has been known for over 25 years. However, extensive pain-related research on this and related compounds has barely begun. As yet, the evidence is insufficient to either rule out or accept the possibility that excitatory amino acids play a role in pain trans-

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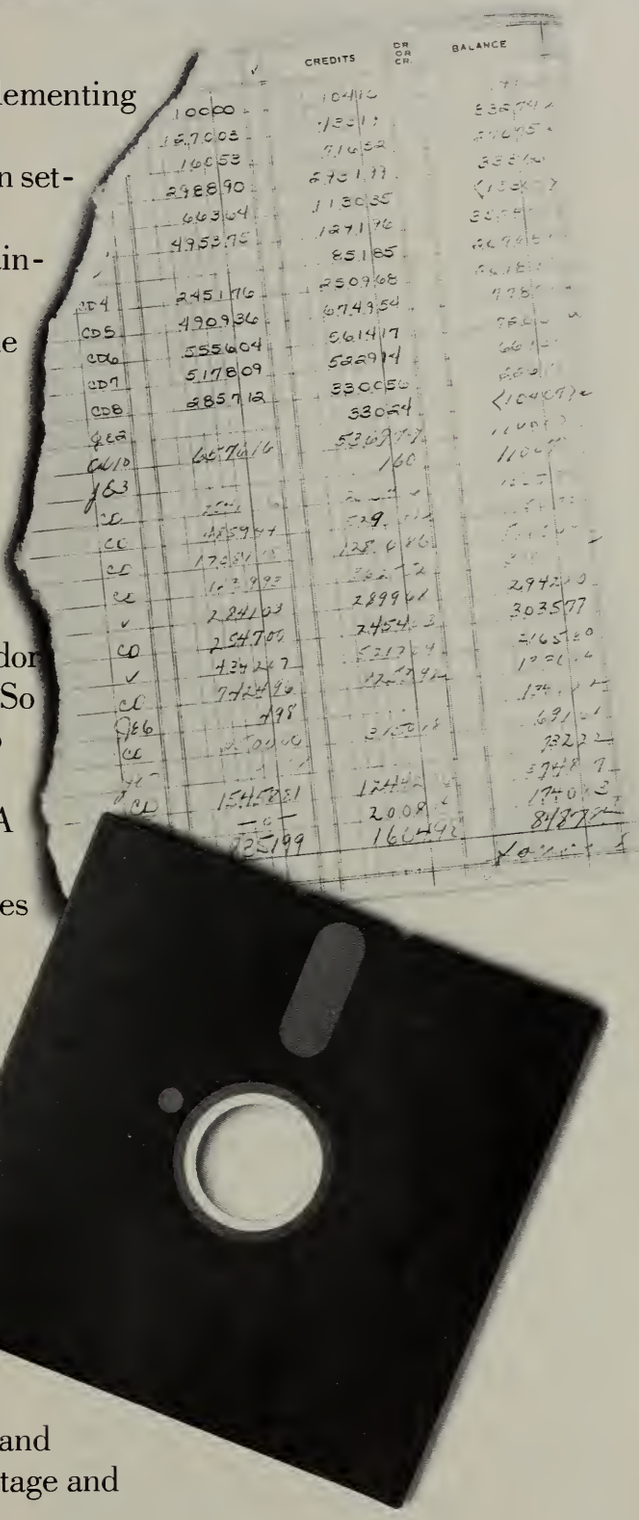

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mission from the skin to the spinal cord. Future studies may provide such evidence.

Incorporating these concepts of neuropharmacology into therapeutic reality is a monumental task in the treatment of pain in the cancer patient. The patient with cancer usually has far advanced disease, when pain control becomes a serious problem. Usually, the neoplasm has finally invaded sensitive nerves, such as the brachial or pelvic plexus, or midline structures, such as the vertebral bodies, signaling an advanced disease state. Because of the usual bilateral aspect of the pain and the fact that most patients with cancer and severe pain have already had multiple procedures (operations) and treatments, any additional invasive procedure to relieve only the symptoms of pain, and not treat the basic disease, is often unpalatable to the patient. This is especially true of destructive central nervous system procedures such as cordotomy—a time-honored procedure which now is becoming an operation of historical interest only. Open or stereotaxic cordotomy is useful only for unilateral peripheral pain—such as occurs with metastasis to a single site such as the femur, or *unilateral* pelvic plexus pain. Pain originating from the midline is not well treated by cordotomy since it would require bilateral spinal cord lesions. Bilateral cordotomy is often associated with unacceptable neurological deficits, such as hemiparesis or bladder difficulty, or physiologic problems, such as hypotension or "Ondines' curse," a dangerous respiratory depression during sleep. Even though cordotomy can be done easily and safely by stereotaxic techniques, and realizing the presence of a large cancer center, not a single cordotomy has been done by the neurosurgery service at the Medical College of Virginia in the past seven years!

What are the neurosurgical alternatives to destructive central nervous system lesions to control pain? There are essentially only two viable techniques available at the present time: 1) stimulus-produced analgesia (SPA), and 2) implantable analgesic pumps.[3,4]

Stimulus-produced analgesia has considerable meaning in contemporary neurophysiology but is limited in clinical practice. Many investigators have placed electrodes in several targets in the human central nervous system to produce both acute and chronic alterations of pain perception or pain awareness. The tingling effects which come from stimulation of the discriminative, direct lateral spinothalamic or lemniscal systems produce a form of signal masking with a marked reduction in pain level. Pinprick sensation may also be reduced but certainly not abolished. The principle interest in the use of electrical stimulation of the CNS for pain control lies in the fact that it is a nondrug, nondestructive, reversible technique with relatively few side effects. Indeed, when side effects occur they are usually eliminated or at least reduced by the simple reduction in electrical stimulation parameters. SPA should be reserved for chronic pain conditions such as occur in patients with cancer rather than acute pain that occurs with trauma or immediately following an operation. Decisions regarding the use of implanted neuroaugmentive devices for pain control are relatively straightforward. The most important element for success in SPA is location of the electrical stimulation, since this stimulation can only activate existing circuits. Thus, placement of the electrode is more important than the cause of the pain or the stimulus amplitude, frequency, and pulse width.

The percutaneously implanted spinal epidural electrical stimulator electrodes are rather easily positioned in the epidural space. The final position of the electrodes depends entirely on the patient's report of the stimulation paresthesias. Nearly all patients require that tingling overlaps the distribution of the pain. If the percutaneous electrodes are successful, the extension wires are cut off and connected to a permanent receiver implanted in a subcutaneous pocket in the anterior chest wall.

Deep brain stimulation (DBS) implants are generally reserved for cases having unremitting, agonizing pain that is bilateral, deep midline, or diffuse from metastases or of central origin. DBS utilizes a variety of targets, depending upon the clinician and his personal experience. The majority of the targets utilized are either those of the para-aqueductal gray-paraventricular complex or the specific sensory thalamus. Rich communications through the nonspecific thalamus permit good bilateral effects from a unilateral electrode. In general, neuroaugmentive devices share a high degree of efficacy with other established means of pain control. In practice, for over ten years DBS has proven an effective means of pain control in many patients with cancer.

The use of intraspinal or intraventricular pumps to deliver opiates to relieve cancer pain is a significant advance (Fig. 1). This treatment is founded on the scientific discoveries of the multitude of opiate receptors in the superficial layers of the spinal cord and ventricles of the brain and the practical availability of implanted pumps and external catheter systems to

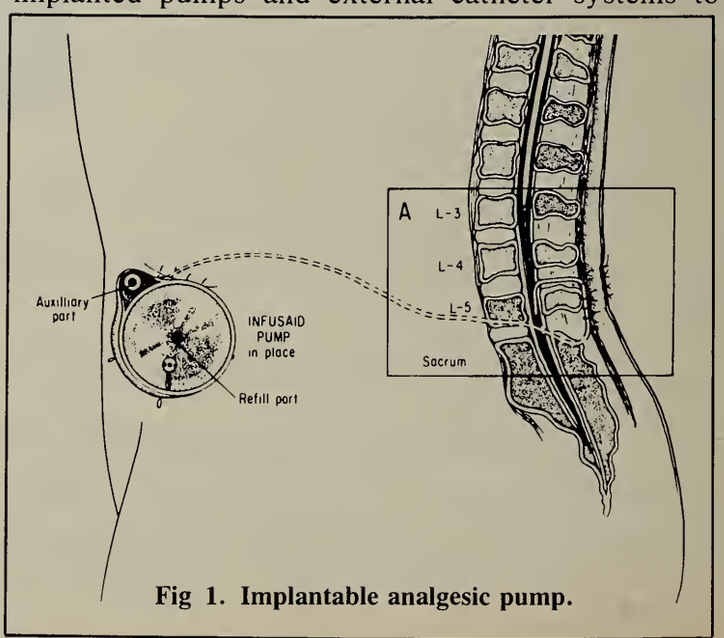

Fig 1. Implantable analgesic pump.

deliver chronic opiates. Why should such a mode of treatment be a major interest in cancer patients? First, it has the promise of controlling pain without the side effects of systemic morphine. Second, it can be employed successfully when systemic opiates are failing, that is, as a last resort. Third, it is most useful for precisely the types of pain that the destructive neurosurgical procedures exemplified by the percutaneous cordotomy cannot help, namely, midline or bilateral pain. The use of spinal opiates depends on proper application of a drug and device in consort. The safe use of intraspinal morphine depends on understanding its pharmacokinetics. There is no question now that spinal epidural morphine can significantly reduce pain due to a variety of causes, including visceral cancer pain. On the other hand, the acute adverse effects of spinal morphine must be balanced against its advantages. Common problems include nausea and vomiting, itching, and hypotonic bladder leading to urinary retention. When spinal opiates are given to patients who are taking systemic opiates, as almost always is the case in cancer patients, respiratory depression is extremely rare. It occurs only when a large bolus intraspinal dose is given or when systemic drug dose is not reduced. When a patient is being treated with epidural morphine, he or she is getting effects from both systemic and spinal morphine. Another pharmacological point is that morphine is effective because it is activating spinal opiate receptors. To get to these receptors, it must diffuse from CSF into the neural tissue of the cord. Diffusion is a slow process. In practice, this means a 30–60 minute delay in action between the injection of a bolus of intrathecal morphine and relief of pain.

Implantation of a catheter or pump necessarily weds the patient to the practitioner. The key to good management is availability to the patient and family and flexibility in managing the pump and supplementary oral medicines. Refilling pumps, changing medications, and assessing pain can be a trying experience and must be organized before implantation of a pump.

In the treatment of pain in the patient with cancer, a holistic or global management approach must be used. Emphasis should be on nondestructive procedures and upon total care of the patient beyond the technique or type of pain control administered.

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Psychological Aspects of Pain Management

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The major psychological reactions affecting pain are anxiety, depression, denial, and regression. Approximately 40% of general medical patients with severe pain have high levels of anxiety.[1] Anxiety usually increases the amount of pain experienced, especially when the patient is frightened by his or her illness, hospitalization, or treatment. In laboratory tests of pain tolerance, anxious subjects had lower pain thresholds than other subjects.[2] The autonomic signs of anxiety (tachycardia, diaphoresis, tremor, shortness of breath, and abdominal or chest discomfort) may be misinterpreted by the physician as solely signs of pain, rather than as indications of coexisting anxiety exacerbating pain.

Significant depressive symptoms also are found in 40% of general medical patients with severe pain.[1] Grief, sadness, demoralization, fatigue, psychomotor slowing, and organic depression of the central nervous system all may impact on how pain is experienced in the medically ill. The helplessness and pessimism associated with depression make it difficult for patients to utilize their own strengths and others' help in overcoming pain. Depressed patients tend to be somatically preoccupied, further increasing pain.

Denial is a common defense mechanism used to block out thoughts or feelings an individual cannot face. Some patients fail to report significant pain, or report it as less severe than their true experience because they are frightened about what may be wrong with them. This phenomenon is well known to clinicians with the pain heralding myocardial infaction, in which the denial or minimization of pain prior to hospitalization is an important contributor to morbidity and mortality.[3]

Regression, a return to more child-like patterns of behavior, is universal in illness. Sick patients, especially those in pain, wish to be comforted, cared for, and freed from the responsibilities of adult life. In moderation this is adaptive and facilitates treatment.

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Regression is problematic when it becomes more extreme. It is difficult to care for a patient who is infantile, overly needy, whining, and unable to tolerate being alone. Sustained or unpredictably occurring severe pain makes regression more likely, and in turn very regressed patients have minimal pain tolerance.

Pain also serves important communicative functions, particularly when the individual may be reluctant or unable to express certain feelings directly. A wide range of feelings can be communicated by pain, including anger at family, physicians or nurses; dependency needs; and fear, e.g., the fear of having a dreaded disease.

Previous learning powerfully affects the pain experience and can often be modified by psychological interventions. The patient's past experiences and models for pain behavior, particularly those of the family, clearly affect his or her pain tolerance and perception. For example, children who grow up in a family where attention is very sparse may learn that being ill and in pain gets them parental love and attention.

Patients' beliefs about what pain signifies can affect their tolerance for it. A patient who believes her joint pain represents an undiagnosed cancer usually complains more intensely than one who believes it is due to arthritis. Patients who are prepared for pain (e.g. before an elective operation) tolerate it much better than patients who have unexpected pain.[4]

Finally, there is evidence that factors in the patient's present environment can reinforce pain behavior.[5] This is usually in the form of "secondary gain", e.g., increased attention from medical caretakers and family for pain, being excused from occupational or domestic obligations, disability payments, and the influence of litigation.

Psychological Factors in Medicating Pain

It is common for physicians to undermedicate acute pain, both by giving inadequate doses of medications and by spacing doses too widely for their half lives. Undermedication of acute pain is especially frequent in patients with a history of narcotics abuse. Some physicians try to restrain opiate dosage to avoid creating further abuse, but addicted patients actually require higher doses than other patients because of their opiate tolerance.

Fixed schedules of analgesics are usually more effective than PRNs for several reasons. Pain is more difficult to relieve after it has become severe than if it is medicated early. A PRN regimen obliges the patient to be vigilant for the early return of pain, so that there will be sufficient time to find and persuade a nurse to get the medication. This keeps the patient's mind on the pain, which works against analgesia. PRN narcotics also paradoxically encourage the drug-seeking behavior they seek to avoid, since the vocal and persistent patient is more likely to receive nursing attention and medication than the quietly cooperative patient.

Confronted with a patient whose pain has been particularly difficult to alleviate, some physicians are tempted to substitute placebo for narcotic surreptitiously to see "if the pain is real." This practice is inconsistent with what is known about placebos. About 35% of patients obtain relief from acute pain following the administration of placebo.[6] The placebo effect does not appear associated with any particular personality style. Good analgesic response to placebo appears more likely with severe than mild pain and is increased tenfold in clinical settings over that in the pain laboratory.[7,8] Some evidence suggests that placebos act via the endogenous endorphin system to bring about pain relief, and studies have demonstrated that their effects can be blocked by naloxone, an opiate antagonist.[9] In general, patients who do the best with placebos are those with whom the physican has the best relationship and can treat with enthusiasm. Patients who have important secondary gain maintaining their pain will tend to respond poorly to narcotics *and* placebos. Surreptitiously using placebo to try to unmask the patient will seriously damage the doctor-patient relationship if the patient finds out the physician is trying to trick him or her, and the reestablishment of trust may be difficult or impossible.

Chronic Pain

Psychological interventions can be extremely helpful in managing patients with chronic pain syndromes. Psychological management is useful even in patients without an indentifiable clinical psychiatric syndrome, and is part of the multidisciplinary approach to chronic pain in most treatment centers.[10] In evaluating patients with chronic pain, it is essential to take a thorough pain history, including the patient's ideas about the etiology, meaning, and prognosis of the pain in order to plan treatment strategies. In this interview the physician should also screen for symptoms of underlying psychiatric disorders including affective, anxiety, and posttraumatic stress disorders, somatoform disorders (somatization disorder, somatoform pain disorder, hypochondriasis); malingering; factitious illness (e.g., Munchausen syndrome); and substance abuse. However, pain should not be diagnosed as psychogenic just because no organic cause is found; a psychiatric diagnosis is appropriate only if its specific diagnostic criteria have been met. Diagnosing "by exclusion" leads to frequent misdiagnosis.

The association of chronic pain with many psychiatric syndromes highlights the frequent need for psychiatric consultation and/or psychological testing. Specific psychiatric syndromes warrant specific psychopharmacological and/or psychotherapeutic treatments. For example, somatic complaints, including pain, are very common in major depression, particularly in geriatric patients. Secondary pain syndromes respond well to treatment of the underlying depression. Even when there is a documented organic cause for pain, patients with coexisting depression usually

tolerate pain better when their depression is treated and they become more hopeful and less somatically preoccupied. From 10-50% of patients with chronic pain have significant coexisting depression.[11,12] It is often difficult to distinguish mild depressive symptoms from the psychiatric syndrome of major depression. The former is often treated with supportive reassurance, while the latter usually requires treatment with antidepressant medications. Somatic signs of depression, such as sleep and appetite disturbances, can be used to diagnose depression in chronic pain patients and should be screened for.[13] Since chronic pain itself often interferes with sleep, appetite and libido, even an experienced psychiatrist may sometimes remain uncertain whether a major depression is present. Therefore, an empirical trial of antidepressants is usually recommended for any chronic pain patient with significant depressive symptoms, with many clinicians choosing serotonergic antidepressants, such as amitriptyline and trazodone.[14,15]

Personality factors which contribute to pain have been hypothesized in patients with chronic pain syndromes. In 1958 Engel described "pain-prone patients" as individuals who were brought up in emotionally distant and physically abusive families and who received parental attention only when sick or hurting. The pain appeared to serve as a punishment to relieve guilt, as they were unable to express their intense anger directly and instead turned it on themselves.[16] This was later postulated by Blumer to be the cause of the high rate of depression in patients with chronic pain.[12]

Psychological strategies are helpful in managing acute and chronic pain whether or not there is an underlying psychiatric disorder. Techniques employed include educational and cognitive strategies, hypnosis, relaxation, biofeedback and guided imagery. Several studies document that patients who are carefully prepared for an operative procedure, including how much pain to expect, tolerate it better.[17,18] This runs counter to the clinical mythology that telling patients to expect pain will make them feel more. In fact, several investigators hypothesize that overestimating patients' postoperative pain in relation to what they actually have minimizes their postoperative distress.[19]

Physicians and patients usually know intuitively that pain increases or decreases relative to how much attention a patient pays to it. This is utilized in treatment strategies which promote distraction.[20] Relaxation, biofeedback and hypnosis are efficacious in reducing pain primarily by decreasing patients' anxiety and attention to pain. For the approximately two-thirds of pain patients who are hypnotizable, direct suggestions may be tried. These include making the affected area numb, tingling or dull, or hot or cold.[21] With practice, motivated patients can be trained to use self-hypnosis, relaxation or biofeedback on their own. They are less efficacious in patients with significant secondary gain or personality factors maintaining their pain. Maladaptive pain behavior that has been reinforced can be a target for treatment in addition to the pain itself. The ward staff or family are instructed to ignore complaining, grimacing and other pain behaviors and to positively reinforce social interaction and activity. Thus patients experience more staff attentiveness for adaptive behavior than for pain complaints, which are gradually extinguished. Such strategies appear to increase vocational and domestic functioning and to decrease use of medical resources.[22]

When patients present to a pain clinic, they are often addicted to narcotics and sedatives hypnotics, and gradual withdrawal is an important part of treatment. As a general rule, whenever the physician takes something away from the chronic pain patient, something should be given in its place. For example, when narcotics are discontinued, aspirin or nonsteroidal analgesics can be substituted, as well as nonpharmacological interventions such as more frequent appointments, physical therapy or a TENS unit. It is also important never to promise patients complete relief of their chronic pain; this outcome is so unusual that this facile reassurance will usually undermine the patient's faith in the physician.

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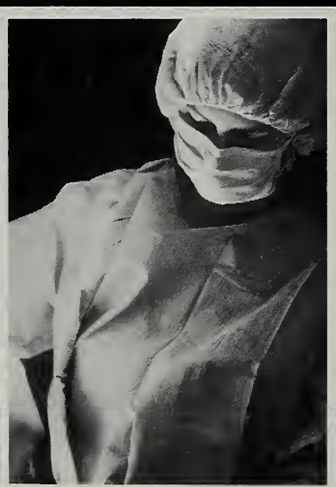

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VIRGINIA AUTHORS

Chronic Compartment Syndrome. Lawrence J. Lutz, MD, and Gerald Goodenough, MD, Salt Lake City, Utah, Don E. Detmer, MD, Charlottesville.

Chronic compartment syndrome typically affects young people who are engaged in endurance sports. The primary clinical feature is a sensation of tightness or aching pain in a defined compartment of the affected limb, starting during activity or hours after activity ceases and lasting for varying lengths of time. The diagnosis is based on the history and on measurement of compartmental pressures. Fasciotomy or partial fasciectomy is the definitive treatment. Am Fam Physician 1989;39:191-6

Clostridial Bloodstream Infections. Christopher W. Ingram, MD, and James N. Cooper, MD, Falls Church.

In a ten-year review at a large community teaching hospital clostridia accounted for less than 1% of all positive bloodstream isolates (26 episodes in 25 patients). All but one of the isolates were clinically significant. Twenty-two patients (88%) had a serious underlying medical condition, and 17 of the episodes (65%) were associated with a bowel source; twelve patients (48%) died of their infection. Clostridial bloodstream infections are particularly clinically significant in patients with serious underlying disease. South Med J 1989;82:29-31

Comparison of Smokers'/Nonsmokers' Attitudes and Exercise Performance During a Six-Week Cardiac Rehabilitation Program. Karen T. Labuhn, RN, and Charles L. Baird, Jr., MD, Richmond.

Data were collected from the medical records of 135 patients who completed a 6-week cardiac rehabilitation program, and the attitudes and exercise performance of nonsmokers were compared with those of initial smokers who (a) quit smoking, (b) decreased their smoking rates, and (c) maintained their smoking rates. Exercise performance was measured in kiloponds (workload achieved) at 20 km for 10 minutes on a bicycle ergometer. The mean increase in exercise performance was similar for matched pairs of nonsmokers and smokers who quit (.44 kp vs .48 kp), and for matched pairs of nonsmokers and smokers who decreased their smoking rates (.53 kp vs .41 kp). It was dissimilar for matched pairs of nonsmokers and smokers who maintained their initial levels of smoking (.44 kp vs .24 kp increase). Smokers who continued smoking at their initial rates also had less positive attitudes toward rehabilitation. Interventions to assist patients with their smoking cessation attempts are discussed. J Cardiopulmonary Rehab 1988;8:326-329

Airway and Dentofacial Development. George M. Meredith, MD, Norfolk.

All physicians and dentists who evaluate the upper airway and dentofacial skeleton in the growing child should be aware of the wealth of pediatric dental and, especially, orthodontic literature that has been published over the past century as it pertains to airway and dentofacial development. The child who has a genetic predisposition towards the dolichocephalic (narrow) facial skeleton, a neuromuscular deficit, and structural upper airway compromise, is particularly at risk regarding development of the long-face syndrome. Furthermore, the child who has a genetic tendency towards mandibular prognathism, tonsillar and tongue hypertrophy, and who is a chronic mouth-breather, is at particular risk for developing advanced mandibular prognathism. Unfortunately, there is little physician exposure to these concepts during medical school years and even during residency training programs. It behooves each specialty to be aware of the diagnostic and therapeutic modalities and concerns of interrelated specialties. The beneficiaries of this sharing of knowledge will be tomorrow's leaders. Am J Rhinology 1988;2(1):33-41

VIRGINIA MEDICAL

EDITORIAL

Pain Management

WHETHER it be trauma, surgical operation, cancer or other chronic disease processes, the effective management of any pain and suffering associated with the clinical problem is a foremost responsibility for every physician. Understanding the mechanisms of pain, its quantitation and the different approaches to pain management are difficult tasks for most of us practicing physicians, and we often need helpful advice for the individual patient.

The purpose of the group of articles in this issue is to provide a better understanding of pain problems and how to deal with them. The combination of authors demonstrates the multidisciplinary nature of pain management considerations. Their advice may help in solution of some of the pain management problems Virginia physicians encounter, but further consultation and the development of treatment programs may be required for some patients. Fortunately, there are two Pain Management Centers available to us when such help is needed. One is at the Medical College of Virginia in the Department of Anesthesiology (Dr. Amir Rafii, 804-786-9162), and the other is at the University of Virginia in the Department of Anesthesiology (Dr. John Rawlingson, 804-924-2283).

WALTER LAWRENCE, JR., MD

War and Anger

THE medical staff meeting had lasted far too long and was far too rancorous for my old physician friend, Gilroy LackLuster. So we decided to have an imported Hayem Shemon beer at Queenie's Tavern. Gilroy was upset that he had become so angry during debate that he did some shouting and arm waving. He claims to be a paternal descendant of Napoleon and a maternal descendant of Mahatma Ghandi, which makes him genetically a warlike pacifist.

"I just can't get over how angry I became tonight," Gilroy said.

"Well, all of us get mad now and then, Gilroy."

"Oh, I was more than angry," he responded. "One more asinine comment and I would have been ready to fight.

"Gilroy, it's over with. No one will remember it in two days, and his screaming and yelling didn't make him look too good, either. You'll be friends again in a few weeks."

"Maybe so, maybe not. I hate to be called names," Gilroy said.

"He didn't do that until after you suggested that his brains had taken a vacation but that nobody noticed until tonight," I reminded him.

He didn't seem to hear me. "It's just like Ireland and the Middle East," he ruminated. "Folks who are not all that different are killing each other because they cannot reach a peaceful settlement. Innocent people are blown up because they happen to walk by a car as a bomb goes off. It's stupid, and both he and I were stupid tonight."

"Gilroy," I said, "you're feeling guilty because you were ready to do him in. But rage can be justifiable. Let me illustrate.

"You will recall that my father-in-law died recently from a lingering illness. Well, he had been operated on

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by a surgeon at a regional university medical center about five years earlier. In the last few days of his life his local physician tried to refer him to that same surgeon for consultation. Not only did the surgeon refuse to see my father-in-law, but he told the referring physician not to call him again because two telephone calls over this one patient were more than enough.

"I had to tell my in-laws that the surgeon outright refused to see him. They had such faith in the man. I had to tell them and it broke my heart. A fellow physician denying them a little touch of human kindness, a friendly hand. All that man had to do was to see him, to pronounce him incurably ill, and to prescribe enough pain medication to keep him comfortable.

"You can talk all you want about reason and rational thought and civilized ways to settle things, but you know, Gilroy, if I had the power and the opportunity, I would nuke him."

HENRY S. CAMPELL, MD

Comprehensive Health Care

SOME time ago, Dr. Arnold S. Relman, Editor of the *New England Journal of Medicine*, suggested the need for a "new and more comprehensive approach to health policy" in the United States.[1] Two recent articles in that journal have contained proposals designed to meet that need.

The Enthoven[2] approach, based on qualified managed care health plans, tries to maintain the pluralistic insurance network. The other plan, presented as "a physicians' proposal",[3] suggests full coverage for everyone under a single comprehensive public insurance program.

The present health system in the United States is not satisfactory and the more government and big business manipulate it the less effective the system becomes. Neither of the above mentioned plans represents socialized medicine, but the trend is everywhere. (See the commentary on the opposite page.) Experience with a national health system in Great Britain has provided a lesson; it does not seem wise for the United States to repeat that experience.

E.L.K., JR.

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POINT OF VIEW

More for Less

The United States has the most technologically advanced health care system in the world, yet millions of citizens have no insurance. We are also the only developed country besides South Africa that does not guarantee health care to all citizens regardless of ability to pay. This situation has been described by Alain Enthoven, a health economist at Stanford as "a paradox of deprivation and excess". In Virginia alone, an estimated 880,000 individuals have no health coverage whatsoever. In addition, at least 20% of Virginians are "underinsured", i.e., would be financially ruined by a major illness.

Health insurance is itself no guarantee against financial disaster, since even patients who are insured have substantial cause for concern. Many employees now pay larger deductibles and/or copayments, sometimes choose from a restricted list of providers (often discontinuing therapeutic physician-patient relationships), and often find themselves lacking coverage they had previously taken for granted.

Traditionally, physicians have practiced medicine and delegated administration to others. Those days are gone. During the past ten years efforts by all insurers to contain costs have resulted in an avalanche of paperwork, increasing requirements for documentation, and a spectacular increase in administrative work. As a result, the U.S. spends 22% of total health care dollars on administration, compared to approximately 12% in Canada and 8% in Great Britain. It has been said that in our drive to preserve autonomy American physicians now tolerate more bureaucratic interference than in any other country.

Many observers now doubt that further piecemeal reforms can help, and that our current crisis requires system-wide reform. The most important concept is that the problems of increasing costs and decreasing access are interrelated. Policies that restrict access further escalate costs. For example, limited prenatal care for pregnant mothers leads to an increase in premature babies whose intensive perinatal care is astonishingly expensive. Paying patients must share the burden of these costs. Thus, in addition to the human losses, the increasing number of uninsured Americans is a fiscal nightmare.

A National Health Program (NHP) offers solutions to many of our problems. Although the words elicit an emotional response from many individuals, a program similar to the Canadian system would reduce total costs and reduce restrictions on both patients and physicians, while providing universal access to care. The key features of such a plan include:

- The NHP would provide universal, comprehensive care, regardless of ability to pay.
- No out-of-pocket payments would be required at the point of delivery.
- Financing for the NHP would come from taxation of individual and corporate income. (This is equivalent to considering all employer-provided benefits as taxable income).
- The NHP would reduce administrative costs by simplifying all existing paperwork under one system.
- Budgets for capital equipment and operating expenses for hospitals would be separate. Capital expenditures would need approval by a regional planning board.

Could a plan similar to the Canadian system work in this country? Canada is similar to the U.S. both geographically and culturally. There have been numerous proposals for a NHP since the 1920s—yet none have garnered sufficient political support to become incorporated into national policy. While there will be strong opponents of such a plan, several considerations now argue in favor of a NHP. First, many public opinion polls have found that Americans overwhelmingly favor such a plan *even if it means higher taxes* (emphasis added). In February of this year a Harris poll found that 55% of Canadians were satisfied with their current healthcare system, as opposed to 20% of Britons and a scant 6% of Americans. Second, many businesses which would have previously opposed such a plan may find it an attractive option as the costs of health care premiums become prohibitive. Third, the Canadians have provided us with a working model—health care for all is not a utopian myth north of the border. Finally, physicians are increasingly unhappy as they spend more time on paperwork. Surveys have found that a majority of physicians (56% in one large study) support a national health plan, but nearly two-thirds assume that their colleagues would not.

A NHP would improve access and reduce costs. Should we be happy with less?

Carolyn M. Clancy, MD
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VIRGINIA MEDICAL OBITUARY

• **Franklin Lynwood Angell, MD,** who practiced radiology in Severna Park, Maryland; Medical College of Virginia, 1947; age 63; died January 24, 1988.

• **R. Bryan Grinnan, Jr., MD,** Norfolk; University of Virginia School of Medicine, 1932; age 81, died February 20, 1989. Dr. Grinnan was an internist specializing in cardiovascular diseases.

• **Pembroke T. Grove, MD,** Winchester obstetrician/gynecologist; University of Virginia School of Medicine, 1936; age 76; died February 1, 1989.

• **Thomas Edward O'Brien, MD,** Falls Church internist; Georgetown University School of Medicine, 1943; age 70; died September 22, 1988.

• **Austin Thomas Williams, MD,** internist who had practiced in both Arlington and Fairfax; Tufts University School of Medicine, 1956; age 59; died February 8, 1989.

Memoir of John R. Saunders 1910-1988

By William A. Cook, Jr., MD

Members of the Lynchburg Academy of Medicine, were saddened by the death of their esteemed colleague and former president, Dr. John Richard Saunders, on November 25, 1988.

Dr. Saunders was born in Saluda, Virginia, on October 2, 1910, the son of Attorney General John R. Saunders and Mrs. Blanche Hoskins Saunders. Upon his graduation from Christ Church School in 1927, he entered Hampden-Sydney College, obtaining his baccalaureate degree in 1931. He received his medical degree from the Medical College of Virginia in 1935.

Following an internship in New Jersey and a short time spent in practice in the coal mining area of West Virginia, he came to Madison Heights, Virginia, in 1937, taking over the general medical practice of the deceased Dr. George T. Harris. During these years he spent many all-night vigils in the rural and semi-rural homes of the area monitoring his patients in labor and doing home deliveries. This fostered his love for obstetrics and motivated his return to the Medical College of Virginia, where he served as resident in obstetrics and gynecology from 1944 until 1946. He returned to Lynchburg in 1946 and except for a one-year absence in 1955 to 1956, when he took further training in obstetrics and gynecology at the Graduate School of Medicine of the University of Pennsylvania, he practiced his chosen specialty in Lynchburg until his retirement in 1976.

Besides being a past president of the academy, he was a diplomate of the American Board of Obstetrics and Gynecology, a fellow of the American College of Obstetricians and Gynecologists, and a member of the South Atlantic Association of Obstetricians and Gynecologists, the Virginia Obstetrical and Gynecological Society, and The Medical Society of Virginia.

He was a deacon in the First Presbyterian Church and as an avid golfer had memberships in the Boonsboro Country Club and the Princess Anne Country Club at Virginia Beach.

He is survived by his wife, Caroline Doyle Saunders, two daughters, Mrs. William R. (Sue) Clark of Wayne, Pennsylvania, and Mrs. Hugh J. M. (Betsy) Jones III of Lynchburg, and four grandchildren.

Throughout the years of his private practice he also served faithfully on the indigent obstetrical service, and after his retirement he continued to serve in the indigent prenatal clinics in the area for several additional years. Not only was he an astute physician and skillful surgeon from the scientific and technical aspects, he was a master of the art of medicine as well. He had the exceptional ability to inspire confidence in his patients that no doubt aided in speeding their recovery.

He was possessed of a charismatic personality that made him unforgettable. He came by his gregarious and extroverted nature genetically. His father, for whom he was named, served four terms as attorney general of Virginia, and it was said by those who knew him that he was so popular as an elected official that he would have easily been elected governor had he chosen to run. Dr. John R., as he was widely and affectionately known, undoubtedly inherited his father's warm personal style, along with a great sense of humor.

In the 1931 "Kaleidoscope", the yearbook of Hampden-Sydney College, the caption accompanying his photograph reads in part ". . . his social gifts, his clever wit and his quick mind make him a most pleasing companion." This was as apropos during his later years as it had been then. His colleagues and friends will sorely miss this "most pleasing companion."

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WHO'S WHO

Songwriter Francis

While his fellow students at the Medical College of Virginia in the early '70s took summer jobs in hospitals, **Dr. Cleve Francis** took to the road with his guitar, singing in motels. Now he's director of cardiac rehabilitation at Mount Vernon Hospital, Alexandria, and making music on radio and television. On World AIDS Day, December 1 last, he presented on international TV the song he wrote to raise awareness about AIDS, "We're All in This Together," which he sang with a chorus of children from the Washington International School. The show was sponsored by the World Health Organization and the American Red Cross.

Dr. Cleve's song about AIDS has received highly favorably reviews from people grappling with the AIDS problem, and through Cleve Francis Productions (PO Box 15258, Alexandria VA 22309), the cardiologist has recorded a cassette for distribution to nonprofit organizations involved in AIDS education and treatment. He has also composed and performed works that honor Dr. Martin Luther King and the veterans of the Vietnam war, and his benefit concerts for needy patients have put five people through Mount Vernon's cardiac rehabilitation program.

Dr. William M. Kramer, Richmond, is the new president of the Virginia Society of Pathology. Virginia's Chief Medical Examiner, **Dr. David K. Wiecking**, will continue to serve as secretary.

The American-Arab Affairs Council has honored **Dr. Charles E. Horton**, Norfolk, with its annual Distinguished Service Award. The award was announced last last year at a meeting of the Council's board in Washington. Dr. Horton, whose specialty is plastic surgery, is president of Physicians for Peace, an organization that operates medical missions to the Mideast.

After 30 years of practice in Clifton Forge, **Dr. Wallace G. Nunley** retired on New Year's Day, turning his practice over to his longtime friend and neighbor, **Dr. Ronald S. Goings**. A University of Virginia man, Dr. Nunley graduated from its School of Medicine, trained there, is now on its Board of Student Aid, and has a son on the faculty, **Dr. Wallace C. Nunley, Jr.**, professor of ob/gyn. Retirement opens up a whole new schedule of volunteerism for Dr. Nunley's favorite charity, the Shrine organization, and the local Shriners lost no time in designating him their next potentate.

An unusual pledge to his favorite radio station brought media attention to **Dr. Walter R. Wallingford**, Norfolk. A classical music buff, he pledged the proceeds of his rheumatology practice for a week to public radio WHRO, guaranteeing a minimum $200. The offer wasn't entirely altruistic, Dr. Wallingford admitted to a newspaper reporter; he wanted to help WHRO, but his practice was new and business was slow. As it turned out, the pledge didn't help his practice a bit, and he had to reach into his pocket to fulfill the guarantee. The news story and radio blurbs drew comments, however, and under different circumstances, he thinks, the idea would pay off. Dr. Wallingford formerly practiced in Newport News. He's a Temple University School of Medicine graduate, Class of 1962.

A very big book year. That's the way 1988 will be remembered by **Dr. Stephen M. Ayres**, dean of the School of Medicine at the Medical College of Virginia. Three medical texts on which he had long been working came off the presses: the third edition of *Care of the Critically Ill*, a definitive work for physicians and nurses coauthored by Dr. Ayres and Dr. Stanley Giannelli, Jr., first published in 1967; the second edition of *Textbook of Critical Care*, which he coauthored with several others; and *Nutritional Support of the Critically Ill*, on which he worked with Dr. Robert Schlichtig, who trained under Dr. Ayres when he was chairman of internal medicine at St. Louis University.

In Virginia, Dr. Ayres is best known as a medical administrator, but his CV is chockablock with recognition for his leadership in the field of critical care medicine. He is a past president of the Society of Critical Care Medicine; was chairman of a 1983 NIH Consensus Conference on Critical Care Medicine; and is a recipient of the Foundation for Critical Care Medicine's Phoenix Award for his pioneering contributions to the specialty.

Dr. John W. Klousia, Alexandria surgeon, is the new medical staff president at Alexandria Hospital.

Photo of Dr. Francis by Mark Dettinger for *Alexandria Gazette Packet*

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Marie L. Michelson, M.D.
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THE SURVEY

We asked what you thought—and you told us!

J. Thomas Hulvey, MD, President, The Medical Society of Virginia

THE purpose of The Medical Society of Virginia's recent mail survey to all Virginia physicians was to determine what both members and nonmembers think about the Society and to get input on ways we might improve. The response was tremendous—of 11,800 survey forms sent, more than 5,000 have been returned as this is written and they are still coming in. The respondents were about equally divided between members and nonmembers.

It's no secret that the Society needs and wants to rebuild its membership. These are complex times for the medical profession, and in order to continue to represent our members and attract new ones, it is vital that we have the kind of input this survey is bringing to us. It is the firm belief of the MSV leadership that we must provide a necessary service, even to those many physicians who belong to their specialty groups, by serving as the one united voice for the entire medical community in Virginia. Based on your responses, we believe that this survey will provide us with some of the information that can make us more responsive and competitive.

The responses are in process of official tabulation, and cumulative data will be available to us soon. However, an *informal* perusal of your answers as they arrived at the Society's headquarters has already given us some good insight into the current concerns of Virginia physicians. We know that there is much work to be done and have already begun examining ways in which we can better address the issues you have raised. The following are just a few of the points that caught my attention as I looked through the returned questionnaires before they were sent for tabulation:

1. A major concern of Virginia physicians is the fact that the medical profession has lost ground in regard to the high public esteem in which it was once held. Our professional dignity has been lost in all of the concern about costs, liability, reimbursement mechanisms, Medicare, etc. It needs to be restored. This is something that you thought that we as a Society should address. I couldn't agree more.

2. While many of you did not characterize yourselves as active in any organized medical society (component, state, AMA or specialty), you felt that an important function of organized medicine is to represent the profession with both state and federal government. This is an area in which we think The Medical Society of Virginia can be particularly helpful—cooperating with the specialty societies to voice our professional concerns.

3. Only about half of the nonmember respondents indicated they had been approached about joining the Society either by a colleague or through the mail. We apparently haven't been convincing enough about membership benefits, nor have we reached all of those physicians who are not MSV members.

4. The three major reasons they had not joined the Society, said the responding nonmembers, are unification, cost, and lack of awareness of the benefits that membership confers. Even many members indicated a surprisingly low awareness of the Society's programs, something we need to begin work on now.

5. It was very disturbing to me to see that many of our members, not to mention nonmembers, feel that the Society operates in a closed framework rather than as the democratic group we really are. We will have to work hard to change that perception—to let people know how easy it is to participate in the Society and to be heard. That's what our House of Delegates, our committees, and our Council are all about.

Although the complete, official results are not yet in, I wanted you to know that the time you took to answer and return the questionnaire has been extremely helpful to your Society. When the official results have been tabulated, there will be much more information in VIRGINIA MEDICAL about the issues and problems raised and how we intend to deal with them. In the meantime, should you have any questions about the survey, please don't hesitate to call me at (703) 628-5141 or the Executive Vice President, Jim Moore, at (804) 353-2721.

Thank you for your participation!

Beware of Buzzwords:

They mininform, insult, and promote ignorance.

These buzzwords were assembled by the AIDS Coalition to Unleash Power (ACT UP). The first seven comments, in quotes, were made by Jody Powell, former White House press secretary, and appeared in *You Can Do Something About AIDS*, published by The Stop AIDS Project, Boston, Massachusetts, 1988.

Term	Problem
Bodily fluids	". . . should never be used without an explanation of which bodily fluids actually contain the HIV virus in concentrations sufficient to transmit the disease . . . Sweat, saliva, and tears are all bodily fluids, but do not carry a threat of HIV infection. Reports on AIDS should make it clear that semen, vaginal fluids, and blood are the concern here."
General population	". . . artificially divides the American people into those who have the disease and those who do not. Everyone who has AIDS—regardless of sexual orientation, race, gender, or how they were exposed to the virus—is part of the 'general population.' "
High risk groups	". . . implies that some kind of demographic trait, rather than behavioral practice, is responsible for AIDS exposure." *Appropriate Term:* High risk behavior
AIDS victims	"People with AIDS are not victims; they are people struggling to live normal lives in the face of a fatal disease. We don't refer to people with other diseases as victims . . ." *Most Preferable Phrase:* People with AIDS
HIV virus vs AIDS	"Many people still confuse exposure to the HIV virus with the disease itself. More than one million people are believed to have been exposed to the virus; some 50,000 actual cases have been reported."* Always explain the difference.
Condoms	"Reports recommending condom use to reduce the risk of HIV exposure should clearly state that latex condoms with a spermacide are preferable (natural lamb condoms may not provide the necessary protection.)"
Intimate sexual contact	". . . a polite phrase that doesn't tell the reader anything useful (many people regard kissing and fondling as intimate). Certain sexual practices—especially unprotected anal intercourse—are known to pose a much greater chance of HIV transmission than others. Articles should make this clear."
Innocent victims	A term sometimes applied to children with AIDS or those who contracted AIDS through blood transfusions; a value judgment that implies that some people with AIDS may be guilty of something. "Victims" is also a problem (see above).
AIDS carrier	The term "carrier" is reminiscent of the typhoid hysteria of the 1920s and can incite similar reactions. *Appropriate Terms:* HIV (antibody) positive person or person with AIDS, depending on condition.
AIDS activism vs gay rights	AIDS activist groups are sometimes incorrectly called gay rights groups. While some AIDS activists also campaign for gay rights, and some issues may overlap, the two subjects should not be confused.
Having sex	Vague; see "Intimate sexual contact" above.

*Outdated figures

VIRGINIA MEDICAL
MAY 1989

What You Should Know About the Proposed "Safe" Harbors

By John D. Grad and Michael P. Logan

Any physician who is involved in a medical limited partnership, in the leasing of equipment, or the ownership of a laboratory or hospital or any entity that provides medical services to which the physician refers, or who is involved in a contract by which that physician is paid for medical billing services—any such physician may be committing a felony. The new federal anti-kickback regulations threaten a revolutionary reworking upon the medical/economic system as we know it, and virtually no physician will be left unthreatened.

Since 1977 it has been a felony for health care providers participating in Medicare or Medicaid to offer, solicit, or receive "remuneration," including bribes, for the referral of patients in these programs. The language of the statute[1] is so broad that in 1980 the Congress clarified that to be held criminally responsible a health care provider must "knowingly and willfully" violate the statute's provisions. These are terms of art in the criminal law, and generally require that the government prove that a physician (or hospital or other provider) purposely violated the law, knowing the actions were illegal.

The statute states in principal part:

Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe or rebate) directly or indirectly, overtly or covertly, in cash or in kind (A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part [by Medicare or a state health care program] or (B) in return for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing or ordering any goods, facility, service or item for which payment may be made in whole or in part [by Medicare or a state health program] shall be guilty of a felony . . . .

The statute also provides for similar penalties for anyone who offers to pay or does pay any remuneration for the furnishing of services or goods which are reimbursed by Medicare or Medicaid.

This language is magnificent in its breadth and, if literally interpreted and prosecuted, would make a felon out of any physician who refers patients to entities in which he has an ownership interest or who engages in other common medical-mercantile activity. To date, prosecutions have generally been confined to flagrant cases of bribes and illegal kickbacks. However, one influential Federal Court of Appeals held in a 1985 case that an intent to induce referrals was sufficient to constitute a violation, even when the payment in question

---

John Grad is a member of the Virginia, District of Columbia, and New York bars and is counsel to the Alexandria Medical Society. Michael Logan is one of his partners. The ideas expressed in this article are their personal opinions and not necessarily those of their clients. Address correspondence to Mr. Grad at PO Box 1417-A44, Alexandria VA 22313.

was also intended to compensate for services.[2]

In 1987 Congress made two basic additions to the law. First, it provided for civil penalties for violating the act. A health care provider can now be excluded from Medicare and Medicaid programs for violations. Secondly, Congress directed the Department of Health and Human Services to develop "safe harbor" guidelines.[3] The purpose of the safe harbor guidelines is to identify practices which will not be subject to criminal prosecution and will not provide a basis for exclusion from Medicare/Medicaid. The Department has now proposed these safe harbor rules, and they are rather scary. Indeed, fitting into any of them as proposed is extremely difficult; the effect instead is to put the medical community on notice that many practices previously thought not illegal may now render a physician subject to prosecution or program exclusion.

A review of the proposed regulations is instruc tive. Be aware when reading them that these types of activities will be the ones that the government will be particularly interested in reviewing.

1. Investment Interests.

Dividends or payments received by a physician from stock or debentures in a corporation to which he/she refers patients are not illegal so long as the assets of the corporation are worth more than $5 million and there are more than 500 shareholders of record.

Questions: Is it illegal to accept payments from a corporation worth less than this amount and/or with fewer shareholders to which a physician refers patients? Can a physician own stock in a laboratory and receive dividends? A diagnostic center? Optical shop?

The Department seems not to be particularly bothered by physicians prescribing medications manufactured by large, publicly-traded pharmaceutical houses. However:

On the other hand, many commentors have described to us situations where health care entities sell limited partnership interests at nominal cost solely to investors who are in a position to make referrals to the entity, and where the profit distribution in the first year, and each year thereafter, is substantially in excess of the original investment. Competitors of these entities complain of losing a significant share of the market to an entity that establishes a limited partnership with physicians in a service area. We have been urged not to include a "safe harbor" for such practices.

And indeed, the Department hasn't.

Potential situations affected include:

- Joint ventures with hospitals,
- Physician-owned hospitals,
- Physician-owned laboratories,
- Physician-owned nursing homes,
- Physician-owned physical therapy centers,
- Physician-owned surgery centers,
- Physician-owned pharmacies and optical shops,
- Any entity owned by a physician to which a patient is referred.

2. Space Rental.

The Department's comments about space rental are illustrative:

The antikickback statute is so broadly written that it could be interpreted to cover rental payments where one party is in a position to make referrals to the other party, even if there is no explicit or implicit understanding regarding referrals. While many rental arrangements are legitimate, we have been informed of many situations where rental payments were simply a device used to mask the real nature of the payments, that is, to induce referrals.

Examples of these illicit arrangements are rentals at above-market value "with the space being used solely to provide care or service to patients referred by the physician," rent at above-market value with an agreement that the physician will refer his patients to the doctor/landlord, or short-term leases with the rent varying, based on the number of referrals from the doctor/landlord. According to the Department, these situations "obviously fall within the scope of the antikickback law, and provide the potential to abuse the Medicare and state health care programs." Given these "abuses," the safe harbor offered is very narrow, and a lease will fall within the safe harbor only if it is 1) in writing, 2) for a term of at least one year, and 3) the rent does not take into account the volume or value of any referrals of business between the parties reimbursed by Medicare or Medicaid.

Questions: They are numerous. For example, can a physician sign a "shopping center lease" in which the rent paid to a commercial landlord varies with the revenues earned? Can a physician charge a flat fee for space rental for a tenant's Medicare patients but a sliding scale for nonMedicare patients (who are not covered by the regulations)?

3. Equipment Rental.

The Department's concerns are similar to those relative to space rental:

We have had described to us arrangements where a provider rents equipment from a hospital and reimburses the hospital on an hourly basis each time he or she uses the equipment. Under this type of arrangement, the hospital knows it will be paid a fee by the provider each time it refers a patient to the provider for services requiring the use of the equipment. In another case, an ophthalmologist may rent diagnostic equipment to an optometrist at a rate significantly below the usual market rate. In this instance, there is an understanding between the parties that the rate will be adjusted periodically depending on the referral rate of patients from the optometrist to the ophthalmologist. The reduction in the rental charge, which becomes larger as the number of referrals increase, could obviously be construed as the offer of remuneration in order to induce referrals.

The safe harbor offered by the Department is similar to the space rental safe harbor: There must be a written lease for a term of at least one year, with the value of the lease not tied to the rate of usage or referrals. The rental terms must be at fair market value.

There must be thousands of doctors in Virginia who, rather than buying equipment in the name of their practice, have bought equipment individually (or with their partners) to lease to the practice.

Questions: How many of these thousands of arrangements are truly at market value? How many are independent of volume or actual usage? Lease arrangements originally commenced for the purposes of obtaining favorable tax treatment may in fact be illegal under the kickback laws.

4. Personal Services and Management Contract.

While a physician or medical group can legally perform certain services for another physician, such as billing or collection, these arrangements could be illegal if they are "intended to induce referrals" or if the amount of the "payment varies with the volume of referral." An example of an improper arrangement provided by the Department is as follows: *An orthopedist is under a contract with a physical therapist to provide billing services for patients he or she refers for the service, thereby receiving compensation in an amount that varies directly with the volume of referrals.*

This is termed "abusive" by the Department.

The Department proclaims that it has established a safe harbor for "joint ventures and other arrangements involving payments for personal services or management contracts, but only if certain standards are met and safeguards are present to limit the opportunity to provide financial incentives in exchange for referrals." The safe harbor terms are very stringent: The parties must agree in writing, for a term not less than one year, for compensation at a fair market value at an arm's-length basis which does not take into account the volume or value of any referrals of business between the parties that is reimbursed by Medicare or Medicaid.

5. Sale of Practice.

Example: Doctor A sells his practice to Doctor B.

The sale of a practice falls within a safe harbor if the sale is complete within one year and the selling physician will not afterwards be in a professional position to make referrals to the buyer after one year.

Questions: Are installment payments now illegal? Will consulting arrangements made part of the sale violate the rule?

6. Referral Services.

Example: A physician pays a fee to be listed on a service's recommended physician list.

These fees are within a safe harbor if the service does not exclude any qualified physician; the charge is made equally to all physicians and is reasonably related to the cost of operating the service; the service does not restrict the manner in which the physician provides services, except that it can require that they be rendered at a reduced rate; and the service discloses to the patient how it selected the physician and the nature of the relationship between the service and the physician.

Question: Preferred provider organizations were purposely left out of the proposed safe harbors, DHHS preferring to examine each PPO on an individual basis. Are PPOs now unsafe?

7. Warranties.

Example: A physician purchases a machine from a company which carries a warranty.

For a warranty to fall within the safe harbor, it must have been issued at the time of original sale and must relate to the material or workmanship of the machine. Also, the warranty can only reimburse the physician for the economic loss suffered by the physician from the nonoperation of the machine.

8. Discounts.

Example: A physician buys vaccines from a supplier and receives a volume discount.

A discount falls within the safe harbor if the physician receiving the discount reports its receipt to the state agency on the applicable cost reporting mechanism and reduces the charge to the Medicare/Medicaid program or the patient by the full amount of the discount.

Question: Does this require physicians to sell vaccines or other medications at cost? Should Medicare patients receive different prices (reflective of a discount) than nonMedicare patients? Does the Board of Medicine (Pharmacy?) really care what doctors pay for drugs?

9. Employees.

Example: A physician hires another physician to work for him.

Payments made to employees fall within a safe harbor if the person is a bona fide employee. The proposed rule makes reference to the Internal Revenue Code definition of employee used for determining withholding requirements. It is not crystal clear whether hiring someone puts them into the safe harbor.

Question: Many physicians are hired on an independent contractor basis to obtain favorable insurance and tax treatment. Do payments received by virtue of their work with a patient violate the rule since they are not "employees"?

The Department of Health and Human Services claims that "We have attempted in these proposed regulations to permit physicians to freely engage in business practices and arrangements that encourage competition, innovation and economy." However, the thrust clearly is aimed at decentralizing medical services and preventing physician control of or profit from auxiliary health care providers or services. The potential result in our view is not decentralization, but de-

stabilization of great magnitude.

What should a physician do if involved in business relationships that may be subject to scrutiny? Our advice, first, is not to panic. We believe that there are millions of relationships and situations nationwide that are potentially violative of the Act, as it now seems to be interpreted under the guidelines. Clearly, the Department will prioritize and, hopefully, provide a better indication of what situations it finds particularly grievous. An earlier version of the regulations provided that the Department would be able to give advisory opinions concerning whether certain relationships violated the antikickback law. At the urging of the Department of Justice, this provision was removed. (The Department felt that it was inappropriate for another agency of the government to give advice in specific situations as to what was or was not a criminal act.) Nevertheless, a "common law" comprised of actions and nonactions of the Department should soon take place and provide doctors some guidance. Given the general aggressiveness of the current Inspector General of the Department, we expect civil and criminal prosecution to step up. Remember also, as of this writing, the regulations are not final. There may be some changes and some reason may be injected into the situation.

Second, we advise moderation and prudence. It is the flagrant kickbacks that have been prosecuted to date. Use caution, care, and good common sense until the legal picture becomes clearer.

Third, we advise you to consult with your lawyer and your accountant about existing relationships as soon as practicable. You should certainly consult with your counsel prior to formation of any new relationships to make sure that they do not run afoul of the law.

[1]Section 1128(b), Social Security Act

[2]*United States v Greber*, 760 F.2d 68 (3rd Cir 1985)

[3]Medicare/Medicaid Patient and Program Protection Act 1987, Pub 1 No 100-93, 101 Stat 697, 42 USC sec 1320a-7b

MEDIBYTES

No sooner had an AIDS patient agreed to a cash settlement of his malpractice suit against **Dr. Duane G. Wombolt** than the jury returned to the courtroom with a verdict exonerating the Norfolk nephrologist of all liability. The plaintiff had asked for $1 million but settled for $125,000; the trial lasted a week. Hospitalized by Dr. Wombolt for a kidney ailment, the 36 yo male plaintiff contended the physician 1) failed to tell him he had tested positive for antibodies to the AIDS virus and 2) prescribed medication that hastened the onset of the disease. Not guilty of either charge, said the jury--but by that time Dr. Wombolt's attorney had made the settlement offer because, he told reporters, he was worried the jury might be hung and a second trial would be expensive.

Is a PPO plan being offered in your area? If so, you cannot be excluded from that PPO if you are willing to meet its terms and conditions for payment. Virginia's PPO statutes give all Virginia physicians that right in a provision introduced by The Medical Society of Virginia when the law was drafted. The provision prohibits insurers from discriminating against or among health care providers.

Thanks to an endowment from the physicians who practice in Norton as Internal Medicine Associates of Southwest Virginia, Clinch Valley College in nearby Wise has a new merit scholarship fund. The endowment provides for an increase from one scholarship of $1,000 in 1988 to four at the same sum in 1991. One of the internists, **Dr. Charles P. Maine**, is a CVC alumnus and is on the college's Advisory Council. Joining him in the gift were these three associates: **Dr. John Martin Prince, Jr., Dr. Steven R. Prince** (they're brothers), and **Dr. A.R. Joshi.**

At the AMA meeting in Chicago in June, **Dr. H.C. Alexander III**, Roanoke, will be running for election to the Council on Medical Services. At the AMA meeting in Dallas in December, **Dr. Percy Wootton**, Richmond, was elected to the Executive Committee of the Forum on Medical Affairs. The Forum's annual programs at the AMA's interim meetings deal with important issues facing the profession. Both men are past MSV presidents and present AMA delegates.

The Lynchburg Academy of Medicine is the latest participant in the Voluntary Medicare Assignment Program for Physicians (VMAPP), under which physicians voluntarily accept Medicare assignment as full payment for eligible patients. The Albemarle County Medical Society was the first component society to sponsor the program, in 1987, and the Norfolk Academy of Medicine followed suit soon after. All three programs operate in close cooperation with the local agencies on aging. --A.G.

Pulmonary Infarction with Cavitation: Case Report

Daniel M. Becker, MD,
B.E. Robinson, MD, M.R. Dagostino, MD,
T.L. Pope, Jr., MD, and Kuldeep Teja, MD,
Charlottesville, Virginia

CAVITARY lung disease can result from infection, neoplasm, vasculitis, and pulmonary infarction. The latter would represent an unusual but dramatic manifestation of a common condition. We are reporting a patient with extensive venous thromboembolic disease who presented with a large cavitary lesion on chest x-ray.

Case Report

A 57-year-old man was admitted to the University of Virginia Hospital with fatigue, shortness of breath, and chest pain. He had been ill for a week and had received erythromycin for a presumed pneumonia. He had no significant past medical history, but each day for many years he drank a fifth of hard liquor and smoked one-half pack of cigarettes.

Physical examination revealed a chronically ill appearing man, oriented only to person, with blood pressure 90/60 mm Hg, pulse 150 and regular, respirations 20, and temperature 36.8° po. Jugular venous pressure was estimated at 12 cm H_2O, and bibasilar rales were present. The liver scan was estimated to be 12 cm. He had marked pitting edema of the left upper extremity and both lower extremities. The remainder of the exam was unremarkable.

Chest x-ray showed a large cavity on the right and bilateral pleural effusions (Fig. 1). The electrocardiogram showed atrial flutter. Other laboratory findings included an arterial blood gas with pH 7.5, pCO_2 31 mm Hg, pO_2 96 mm Hg (on 2 liters of oxygen), BUN 46 mg/dl, creatinine 1.1 mg/dl, albumin 2.2 gm/l, GGT 133 u/l (nl 18-60), alkaline phosphatase 393 u/l (nl 35-135), WBC 10,900 with normal differential, and hematocrit 33% with MCV 88 fl. He was treated with intravenous digoxin and procainamide for the arrythmia. Thiamine and $MgSO_4$ were also administered.

From the Departments of Medicine (Drs. Becker, Robinson and Dagostino), Radiology (Dr. Pope), and Pathology (Dr. Teja), University of Virginia School of Medicine. Address correspondence to Dr. Becker at Box 494, University of Virginia Health Sciences Center, Charlottesville VA 22908.

Originally presented at a Clinical Pathological Conference on April 6, 1988.

Fig. 1. Chest x-ray shows large cavitary areas in right midlung zone and an infiltrate in left lower lobe.

Fig. 2. Computed tomography shows pulmonary infarction with cavitation (arrows).

On the second hospital day he complained of diffuse abdominal pain and developed a low-grade fever. An abdominal ultrasound exam was negative. An echocardiogram showed globally decreased left ventricular function ejection and a pedunculated left ventricular thrombus. Chest CT revealed several irregular cavities and a small pneumothorax (Fig. 2). The PPD was negative and despite repeated attempts at sputum induction, no adequate specimen could be obtained. He required rapid atrial pacing to restore normal sinus rhythm. He was treated empirically with clindamycin. Later that day he suddenly developed right arm and face weakness. A head CT was negative, and he was started on intravenous heparin.

On the third hospital day atrial flutter recurred with a ventricular rate of 150 and a blood pressure of 85/60 mm Hg. He received more intravenous digoxin. The antibiotic was switched to cefoxitin. Thoracentesis yielded bloody fluid with LDH 1614 u/l, glucose 85 mg/dl, protein 3.6 gm/l, and WBC 1900 (49 segs, 46 lymphs, 4 monos, 1 eo), and pH 7.26. Metoprolol was started for the arrythmia, but the patient became hypotensive and more dyspneic after one dose. Fluid resuscitation restored the blood pressure.

On the fourth hospital day he spontaneously reverted to a sinus rhythm but developed worsening abdominal pain, hypotension, and an anion-gap metabolic acidosis. He was transferred to an intensive care unit, where his antibiotics were changed to metronidazole and ticarcillin/clavulinic acid. Repeated attempts at central venous access via internal jugular and subclavian approaches were unsuccessful, yielding no blood return. Eventually a femoral Swan-Ganz catheter was placed, but no wedge tracings could be obtained. The hypotension and acidosis progressed, and the patient eventually died in electromechanical dissociation.

Autopsy

The findings at autopsy were most striking in the lungs, heart, and central veins. The superior vena cava was completely occluded by thrombus, which extended into the innominate and jugular veins. The pulmonary arteries to both lungs were filled with thrombus which extended into the secondary and tertiary branches. There were multiple infarcts in both lungs, ranging in size from 2-8 cm. Some of these areas were necrotic, with clear cavity formation seen in a right upper lobe infarct (Fig. 3).

The heart was enlarged, with four-chamber dilatation and left ventricular hypertrophy. There were no valvular abnormalities, but a papillary muscle in the right ventricle was necrotic. There was multifocal myocardial necrosis, judged to be at least one week old, involving the anterior septum and a healed infarct in the posterior wall of the left ventricle. Mural thrombi were present in both ventricles. There were severe atherosclerotic changes in the right and left anterior descending coronary arteries.

Additional significant findings included thrombus in the left femoral vein, passive hepatic congestion, and cerebellar atrophy consistent with the alcohol history. There were no "occult" malignancies, the bone marrow was normal, there was no evidence of alcoholic liver disease, and there were no cerebral or bowel infarcts.

Discussion

This patient presented as an alcoholic with cardiomyopathy and a cavitary lung lesion. After developing focal neurological signs and severe abdominal pain, possibly due to systemic emboli, he became hemodynamically unstable and could not be resuscitated. The autopsy findings of proximal venous thrombi and pulmonary infarction with cavitation had not been suspected. It remains unclear why this patient developed such extensive venous thromboembolism. There was no underlying malignancy or myeloproliferative disorder. Congestive heart failure was clinically and pathologically evident and remains this patient's most clear-cut risk factor for venous thromboembolism.[1]

Fig. 3. Autopsy specimen of right lung showing necrosis and cavitation.

The differential diagnosis of cavitary lung disease should include malignancy (either primary, or metastatic), infection (bacteria, fungi, nocardia, mycobacteria, and parasite), vasculitis (granulomatous, rheumatoid), sarcoidosis, pneumoconioses (coal miner's lung, silicosis), and, as in this instance, pulmonary infarction.[2] The infarction leading to the cavity may be due to bland or septic emboli, and the cavity may be primarily infected, secondarily infected, or remain sterile.[3] The last category is relatively unusual and represented by this patient. The distinction between an infected and noninfected cavity may be difficult, since fever and leukocytosis are associated with infarction alone. The cavitation usually develops within two weeks of the infarction, and it is not unusual for several cavities to develop.[4] The cavity size is often large, averaging more than 4×4 cm in a recent radiographic case series.[4]

Among reported series the mortality of this illness is high, approximately 50%. The death rate is even higher in patients with infected cavities. Morbidity may include pneumothorax, empyema, and bronchopleural fistula.[2,4,5] Treatment should include appropriate anticoagulation; use of antibiotics in patients with fever, purulent sputum and leukocytosis; and consideration of thoracotomy with resection of the necrotic area.

Although this complication of pulmonary embolism is described in the literature, it is not often recognized prior to death. In retrospective and autopsy series,[2-5] close to 50% of the patients had a postmortem diagnosis, as in our patient. Standard textbooks of pulmonary medicine do not associate cavitation with bland infarction.[6] Cavitation is certainly not a common complication of infarction. Among 52 well-documented pulmonary and carefully followed infarcts in the Urokinase Pulmonary Embolism Trial, none went on to cavitate.[7] Infarction from pulmonary embolism is more common in the setting of shock or congestive heart failure. Thus in patients with cavitary lung disease, shock or congestive heart failure in addition to other risk factors for venous thromboembolism should alert the physician to the possibility of underlying venous thrombosis with embolism and infarction.

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How to Report AIDS and HIV Infection in Virginia

Who should report? Every Virginia physician is required by law to report any case or suspected case of AIDS under his or her care. HIV infection is reportable by law in Virginia when the physician needs the local health department's support in patient counseling and epidemiologic tracking. Reports are kept confidential, as the law specifies.

What should be reported? The presence of a reliably diagnosed disease at least moderately indicative of an underlying cellular immune deficiency, with no other known underlying cause of cellular immune deficiency nor any other cause of reduced resistance associated with that disease, should be reported as AIDS.

Only patients who have positive blood tests for HIV antibodies as demonstrated by at least two enzyme-linked immunosorbent assays (done in duplicate at the same time or singly at different times) and another testing procedure, such as the Western blot, should be reported as having HIV infection.

When should I report? As soon as possible after you first provide care for the patient.

Where should I report? To the local health department serving the jurisdiction in which your practice is located.

Prepared for VIRGINIA MEDICAL by the Virginia Department of Health

Grand Rounds: Takayasus' Arteritis

From the Medical College of Virginia/Virginia Commonwealth University.
Case Presentation by F.P. Duckworth, MD
Radiology by K. Souch, MD
Clinical Discussion by W. Neal Roberts, MD

Presentation of Case

Dr. Duckworth: C.B., a 30-year-old woman, saw her physician in March of 1985 for exertional dyspnea. Investigations revealed hypertension and dilated cardiomyopathy, which were controlled with digoxin, furosemide, and captopril. In November 1986 an echocardiogram revealed a slightly thickened left ventricular wall and normal LV ejection fraction.

In December 1986 the patient began to experience claudication of her legs which persisted over the next two months. Her right posterior tibal pulse was diminished. Doppler exam of the lower extremities was inconclusive. Angiogram demonstrated bilateral renal artery stenosis and narrowing of the abdominal aorta. Antinuclear antibody, rheumatoid factor, and complement levels were all normal. Hepatospenomegaly raised the question of amyloidosis; a rectal biopsy was performed and was normal. The patient was referred to the Medical College of Virginia.

Physical examination revealed an afebrile, well-developed and well-nourished white female in no acute distress. Her blood pressure was 140/80 in both arms. No carotid bruits were found. The right posterior tibial pulse was absent and the other lower extremity pulses were diminished. The chest was clear and the cardiac exam were normal. A palpable, nontender liver edge was felt. Urinalysis showed a trace of protein. She was mildly anemic. Her chest radiograph showed a normal heart size and clear lung fields. EKG showed a normal sinus rhythm and left ventricular hypertrophy by voltage criteria only. An arteriogram was repeated to define the extent of her arterial disease.

From the Department of Medicine, Division of Rheumatology, Allergy and Immunology. Address correspondence to Dr. Roberts at Box 647, MCV Station, Richmond VA 23298.

Presented on November 19, 1987.

Radiology

Dr. Souch: The patient underwent thoracic and abdominal aortography; subtraction views showed the ascending aorta and great vessels normal in appearance. However, in the ascending thoracic aorta there is a smooth tapering of the aorta, some dilitation of the intercostal vessels in the lower thoracic aorta, and narrowing of the upper abdominal aorta. An AP view of the abdominal aortogram (Fig. 1) shows there is a smooth narrowing of the right renal artery approximately 3-cm long. The right kidney is somewhat smaller than the left kidney, and there is also a shorter area of stenosis of the left renal artery.

Takayasu's arteritis has been divided into categories based upon the areas of involvement. Type I encompasses only the aortic arch and the great vessels; Type II is extensive with involvement of the arch as well as the thoracic and abdominal descending aorta; Type III, which is the least common, includes involvement of only the descending thoracic or abdominal aorta, as in this patient. Findings generally include areas of stenosis and occasionally complete occlusion. There can also be fusiform and sacular aneurysms or dilatations. There may be findings on the chest radiograph, including dilatation of the ascending aorta, calcifica-

tion in the aorta, and occasionally rib notching. In this patient, because her involvement was primarily the abdominal aorta, the chest film was normal.

There was no involvement of the celiac axis and the spleen was not felt to be large. The left kidney was larger than the right kidney. The left kidney does have a double collecting system, which may partially account for its larger size, but the right kidney was also atrophic.

Discussion

Dr. Roberts: Takayasu's arteritis is an idiopathic form of inflammatory arteritis involving the large arteries, including the aorta and all of its branches and occasionally the pulmonary arteries as well. The original reports describe the extensive involvement of the arch and great vessels familiar to clinicians. However, the extent of involvement and geographic distribution of the area of involvement are variable (Table 1).

The differential diagnosis for this patient was quite confusing at the time she came to her doctor's office at the age of 27 complaining of symptoms of left-sided heart failure without murmurs. Undoubtedly viral and toxic cardiomyopathies were considered first. Her hypertension could have served as a clue that the renal arteries were involved, however. By the time she developed leg claudication and absent pulses 20 months later, a diagnosis of Takayasu's had become quite likely. There is no vasculitis other than Takayasu's that can narrow the aorta to the extent shown in this patient's angiogram.

The delay between onset of symptoms and diagnosis is understandable because the disease is so rare. Still, the differential diagnoses are not very broad when the presenting complaint is claudication in a young woman. The only one with any frequency at all is coarctation. Also included are cystic medial necrosis, iatrogenic ergotism in the catheterization lab, and syphilitic aortitis. Some patients with aortic dilatation from Takayasu's disease develop aortic insufficiency. A wider practical differential comes into play in the early inflammatory phase, when there are some arthralgias and systemic symptoms. At that stage patients with Takayasu's disease could be mistaken for patients with juvenile rheumatoid arthritis, other connective tissue diseases, or endocarditis. If there is fever and malaise, endocarditis should be ruled out.

Pooled data from the 400 or so reported cases of this disease suggest that only about 15% of patients lack thoracic involvement, so that its absence in this patient is an atypical feature.[1] The sex distribution is 9:1 female to male. Takayasu's arteritis typically occurs in people who are 10–20 years old. The absence of a peripheral pulse when all the pulses are examined occurs in 90% at presentation. Left or right ventricular failure as a presenting sign occurs to some degree in one-third of patients and is not widely appreciated. Renal vascular hypertension is present in about half the patients.

Fig. 1. AP view of abdominal aortogram. Note narrowing of the right renal artery.

Table 1. Distribution of Arterial Involvement in Takayasu's Arteritis.[1]

Artery	Percentage
Subclavian	83
Descending Aorta	58
Renal	56
Carotid	43
Ascending aorta	30
Abdominal aorta	20
Vertebral	19
Iliac	17
Innominate	16
Pulmonary	15
Mesenteric	15
Coronary	9
Femoral	8
Brachial	6

Atypical features of this patient's presentation include, first, the fact that there was, even in retrospect, no episode of malaise and fatigue. Sometimes such a phase lasts as long as three months. The systemic inflammatory component of the disease causes fever, malaise, perhaps some myalgias and arthralgias; at the end of the course there is critical stenosis, impending ischemia, and even infarction of organs. The systemic inflammatory phase in the beginning can recur in one- to two-week episodes through the rest of the course. A picturesque feature this patient also did not have is a "face-down" posture. Face-down posture is supposed to arise from the patient's unconscious desire to limit visual symptoms occurring when extension of the neck kinks the carotids. The organomegaly which was detectable on physical exam in the liver/spleen scan is atypical. There is a single reported case of amyloidosis from Takayasu's arteritis. The most prominent feature was proteinuria from renal amyloid—not organomegaly, however. A possible explanation of organomegaly, although never reported, is arteritis of the liver

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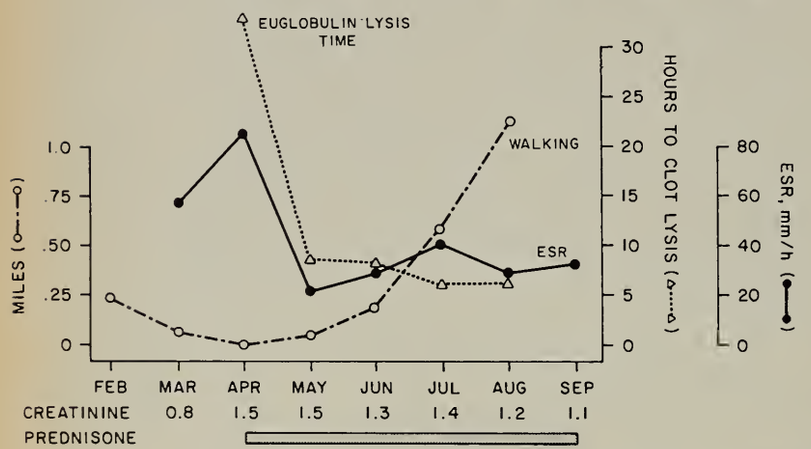
MCV Hospitals

and spleen.

Dr. David Richardson: As a cardiologist, I'd like to raise two points that argue against aggressive medical therapy in this patient. First, when the stenoses reach this severe stage, there must be a considerable amount of fixed scarring. Drugs such as cyclophosphamide may not prove efficacious. My second thought is more philosophical: I'm not sure that the distinction between this disease and coarctation of the aorta is as firm as it seems at first. Do we really know that this patient has active inflammation? Also, because we don't know the cause of coarctation of the aorta, it's possible that some of those patients have scars from previous episodes of arteritis as the etiology.[3] If so, that would imply a self-limited course for at least some patients with arteritis of the aorta.

Dr. Roberts: The fluctuation in ESR and euglobulin lysis time, which were at first elevated, mitigate against the diagnosis of noninflammatory congenital coarctation (Fig. 2); so does her new onset heart failure, which is reported in 30% of the cases of Takayasu's arteritis.

Fig. 2. Note: Normal range for euglobulin lysis time = 2–6 mins. Values shown all greater than control and reported as "prolonged."



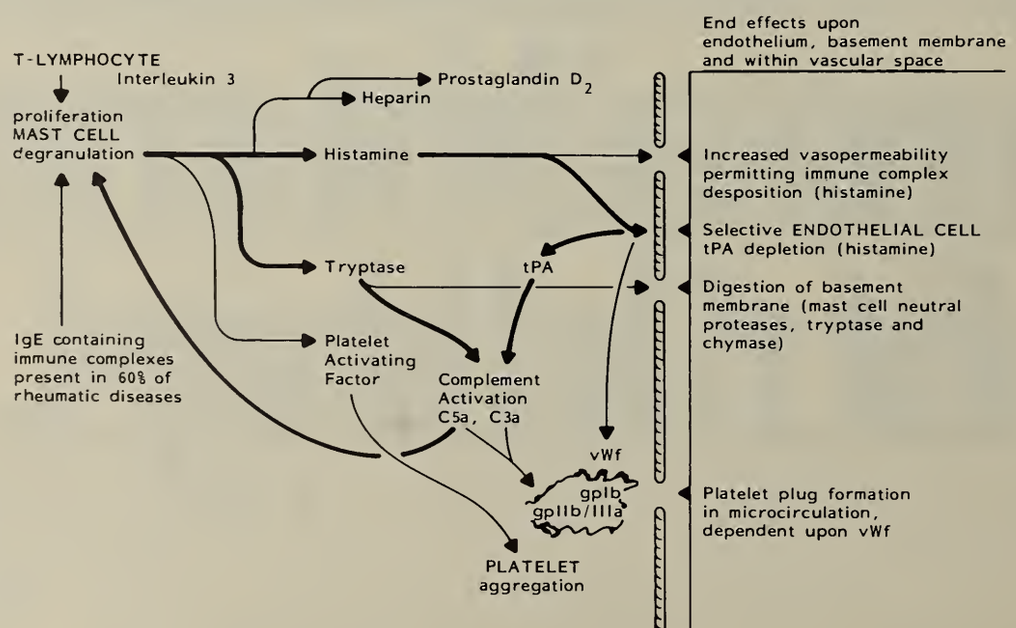
Dr. Anton Schoolwerth: I notice the patient received captopril, which in the presence of bilateral renal artery stenosis can decrease renal perfusion and produce renal failure.

Dr. Roberts: Her physician initiated captopril before renal artery stenosis was diagnosed. Besides the adverse renal effect of arteritis, the radiographic contrast medium could have also contributed to increasing severe creatinine.

Next, I would like to discuss clotting tests in this disease. In the 1960s, Japanese investigators studying Takayasu's arteritis noted a deficit in a functional screening test for plasmin, the euglobulin lysis time. In a Swedish study three of five patients had infinitely stable clots in this test, with the normal time for clot lysis being about two hours in the presence of a normal fibrinolytic system with normal plasmin (and by extension, presumptively normal plasminogen and tissue plasminogen activator). Those patients were the three patients with active disease. A 1986 study from Duke University revealed most normal patients have a reservoir of releasable tissue plasminogen activator (tPA) in their endothelium but little tPA was detected in the patients with vasculitis, even those patients with inactive disease.[4] The euglobulin lysis time therefore appears to be a good test for initial diagnosis of vasculitis but a poor test for following the clinical course because it does not recover when disease activity decreases.

One possible mechanism for intra-arterial clotting in active arteritis is shown in Fig. 3. Immune complexes may cause degranulation of mast cells, resulting in histamine release as well as release of proteases capable of digesting vascular basement membrane. The histamine both increases vascular permeability allowing more deposition of immune complexes and also selectively depletes the vascular endothelium of its tissue plasminogen activator. This physiologic tPA

Fig. 3. Hypothesized Mechanism of Fibrinolytic Defect in Vasculitis.



depletion then renders the vessel surface more vulnerable to inappropriate clotting. No one has yet tried treating acute complications of vasculitis with tPA.

Circulating von Willebrand's factor (vWF) antigen may reflect vasculitis activity. A group from Bristol, England, reported patients with vasculitis and elevated vWF. Five patients who responded to prednisone had falling von Willebrand's factor. The two patients who were steroid-fast and died from complications of their vasculitis maintained an elevated Von Willebrand's factor. It may be that vWF and euglobulin lysis time, both of which are currently available (though rarely ordered) tests from the clinical coagulation laboratory, are more specifically related to the mechanism of the vasculitis than is the ESR.

Finally, the following are summary statements about treatment of Takayasu's disease based upon pooled data. Generally prednisone in a dose of 30–60 mg a day produces a 50% response rate.[2] The systematic symptoms improve with prednisone, but objective improvement in pulses may take as long as three months. Among the 50% who do not respond to steroids, the addition of cyclophosphamide may help half. These data have to be interpreted in light of the fact that there are no good controls. In a Finnish study, 29 severely affected patients had vascular surgery.[5] Seven of them did not have steroids. They remained improved for about five years. Based on this study, there is obvious variability in the natural history of the disease. The steroid responses and responses to immunosuppressive drugs reported in the American literature may represent, in part, the natural history of the disease.

Angioplasty is an important consideration in a patient like Mrs. C.B. with severe bilateral renal artery stenosis; it is just beginning to be used. Endarterectomy is contraindicated because giant cell arteritis is not an intimal disease; it is a disease of media and consequently there is no clear cleavage plane to allow the surgeon to dissect. Dacron grafting done upon an active lesion has a 50% reocclusion rate at five years. Reocclusion occurs mainly in the first six months. In contrast, dacron grafts performed for patients with ESRs less than 40 mm/hr have 90% patency at five years. There is a big difference between being forced to do a dacron graft on somebody who still has active arteritis and doing it electively. Angioplasty, however, may also prove disastrous on friable, actively inflammed arteries. Suppressing the erythrocyte sedimentation before doing a procedure seems to be the critical point in the management of Takayasu's arteritis. One could perform an angioplasty or dacron grafting too early, before the arteritic inflammation had subsided. Following the NIH experience, one might go as long as six months with no response to prednisone alone before trying cyclophosphamide.[2]

ADDENDUM: In the subsequent year of followup, this patient received monthly intravenous pulse cyclophosphamide four times in an unsuccessful effort to taper prednisone to alternate days. When her hypertension became uncontrollable, bilateral renal artery angioplasty was performed. The right renal artery had restenosed and a second angioplasty was performed. Her hypertension subsequently improved.

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PHYSICIAN REFERRALS NEEDED FOR HIV/DRUG STUDIES

Two studies designed to provide important information about the utility of AZT (antiretroviral drug) in HIV infection are underway at the Medical College of Virginia/VCU, and your referrals are needed.

For Study One we need asymptomatic HIV-infected patients with absolute T4 counts of 200-500 for a trial of AZT.

For Study Two we need early symptomatic HIV-infected patients with absolute T4 counts between 200 and 800/mm^3 for a trial of AZT in combination with acyclovir.

Both studies are double-blinded, placebo controlled, multicenter. All participating patients will undergo complete physical/mental assessment and will be followed carefully for the duration of the study, but the referring physicians can continue their care throughout. All study costs are covered by the Burroughs Wellcome Company.

For further information you or your patient can call Dr. Alison Berry or Dr. Martha Mooney at (804) 786-9711. If they aren't available, ask to speak to Martha Gurkin, RN, or Robyn Taylor, RN.

ABSTRACTS

These are abstracts of papers presented May 4-7 at the annual meeting of the Virginia Surgical Society in Williamsburg. Dr. John W. Baker, Jr., was program chairman.

Laser Assisted Balloon Angioplasty. Robert G. Gayle, MD, *Norfolk.*

Use of the hot tipped laser probe as an adjunct to balloon angioplasty is a new technique. Forty six laser assisted superficial femoral artery (SFA) angioplasties were performed on 42 patients. Thirty eight procedures were initial morphologic successes. Eleven procedures were early morphologic/angiographic failures and six procedures were hemodynamic failures despite an improved angiographic picture. Eighteen patients underwent bypass procedures. Indications for laser assisted angioplasty of the SFA, techniques, and limitations will be discussed. Use of duplex scan data in patient selection will also be reviewed.

Ileoanal Procedure: Decreased Stool Frequency with Reversed J Pouch. Harvey Sugerman, MD, Heber Newsome, MD, Melvin Fratkin, MD, Mary Ann Turner, MD, James Mesmer, MD, John Kellum, MD, and Alvin Zfass, MD, *Richmond.*

Although ileal S and J pouches have provided a signficant decrease in stool frequency compared to the ileoanal procedure without a pouch in adults, patients may still have an unacceptable number of stools. In an effort to further reduce stool frequency, we have also used an antiperistaltic reversed-J pouch. The ileoanal procedure was performed in 53 patients from October 1982 through July 1988: 44 for ulcerative colitis and 9 for familial polyposis; 22 had a standard J, 13 an S, and 18 a reversed-J pouch. Pouch function was assessed by questionnaire, balloon pouch volume measurement, scintigraphic percent artificial stool evacuation, and barium defecography. The reversed-J pouch was associated with the fewest ($p < 0.02$) number of total stools per *usual* day (4.8 ± 0.5, SEM) as compared to either the standard J (7.9 ± 1) or S pouch (11.1 ± 3) and also had the fewest number of stools on the *best* ($p < 0.02$) day (2.6 ± 0.3 vs 5.1 ± 0.7 or 7.1 ± 2.3) or *worst* ($p < 0.01$) day (8.1 ± 1 vs 13.2 ± 1.2 or 18.5 ± 4.8) as compared to the J or S pouch, respectively. Reversed-J pouch stool frequency correlated with scintigraphic % pouch evacuation, $r = 0.7$, $p < 0.05$, which was lower ($p < 0.04$) than the % evacuation with the standard J pouch, 29 ± 7 vs 53 ± 8, respectively. There were no correlations noted between stool frequency and scintigraphic or defecographic emptying for the S or J pouches, nor were any differences noted for volume, resting or defecating recto-anal angle for any pouch type. Catheter emptying was necessary in three S and three reversed-J pouches; pouchitis was noted in three J and two reversed-J pouches. The S pouch provided the greatest mesenteric length, the reversed-J pouch the least. Severe anal stenosis ccurred in two reversed-J and two S pouches. Two standard J pouches were removed due to excessive stool frequency. We conclude that the reversed-J pouch has the lowest stool frequency and is the best procedure for patients with adequate mesenteric length. The S pouch may be used for a very short mesentery and standard J pouch for those in between.

Parathyroid Surgery in a Community Hospital. William Gayle, MD, *Lynchburg.*

Hypercalcemia of suspected hyperparathyroidism was evaluated in 113 patients in our community over a 10 year period, January 1, 1979 through December 31, 1988. Four of these patients were determined to have malignancies not of parathyroid origin. Three patients were determined to have parathyroid carcinoma for a 4% incidence of those operated. Of the 69 patients operated, 66% had adenomas, 17% had hyperplasia and 13% had hyperplasia related to end stage renal disease. Twenty-six unoperated patients were hypercalcemic at their last hospitalization in our area. Some of these were going to seek followup elsewhere. However, most of these patients are presumed to have primary hyperparathyroidism and may not have proper followup. Eight of these patients were judged not to be operative candidates at the time of their original diagnosis of primary hyperparathyroidism because of serious other medical problems. At least four other patients have refused surgery. Our followup has demonstrated three operated patients (4%) remain hypercalcemic, presumably due to missed adenoma. One additional patient underwent attempt at selective vascular infusion ablation, but this was not successful and the patient has refused thoracotomy or repeat ablation attempt to date. It is concluded that hyperparathyroidism can be successfully managed in a community hospital setting. However, in this study, a number of unoperated patients remain hypercalcemic and their followup will be discussed as will management of the relatively high incidence of parathyroid carcinoma.

Bariatric Surgery: An Initial Experience. Bruce D. Schimer, MD, *Charlottesville.*

Sixty-three patients underwent operations for weight reduction for morbid obesity at University of Virginia Health Sciences Center from January 1986 to January 1989. There were 55 gastric bypass (GB) and

eight vertical banded gastroplasty (VBG) procedures performed on 51 female and 12 male patients. The preoperative age of females was 40.7 ± 1.5 years and of males was 38.5 ± 2.2 years. Females weighed an average of 307.9 ± 7.5 pounds or 227.7 ± 5.6% of their ideal body weight. Males weighed 384.8 ± 23.5 pounds or 222.3 ± 12.4% of their ideal body weight. Four patients had previously undergone operations for weight reduction elsewhere. Medical diseases frequently seen in the obese patient population were present as follows: hypertension in 60%, cholelithiasis in 52%, arthritis in 35%, diabetes in 19%, and sleep apnea or respiratory insufficiency in 22%. There have been no operative deaths. Significant complications requiring extension of hospital stay or rehospitalization have occurred in two of eight patients (25%) undergoing VBG and 12 of 55 patients (22%) undergoing GB. No serious postoperative metabolic abnormalities have been observed. Iron and B12 deficiencies, known potential long-term nutritional problems following these operations, have occurred in 11 (17.5%) and 5 (7.9%) of patients, respectively. Patients undergoing VBG have lost an average of 26.7 ± 4.3%, 40.8 ± 8.8%, 66.7 ± 4.7%, and 69.0 ± 5.0% of their excess weight at 3 months, 6 months, 12 months, and 24 months postoperatively. Patients undergoing GB have lost 30.8 ± 1.2%, 46.5 ± 2.5%, 63.9 ± 3.3%, and 69.0 ± 8.7% of their excess weight for the same time periods. Despite the somewhat high complication rates, patient satisfaction has been good. These results support the continued use of these operative procedures for the treatment of morbid obesity.

Three Decades of Total Shunts for Portal Hypertension and a Collective Review of Colon Exclusion for Hepatic Encephalopathy. E. Armistead Talman, MD, *Richmond.*

The results of 47 total shunt procedures for bleeding esophageal varices performed consecutively at Johnston-Willis and Chippenham Hospitals in Richmond from 1956 through 1986 are reviewed. Operative survival for Child's Class A was 14/14 (100%); for Child's Class B, 17/21 (81%); and for Child's Class C, 4/12 (33%). One patient who survived the surgery has been lost to subsequent followup. Thirty-three of the 34 patients who otherwise left the hospital were still living at least two years after surgery. Of the 30 patients operated upon prior to 1981 and therefore available for 5-year followup, there were 17 survivors (57%). Forty-two percent manifested some degree of hepatic encephalopathy, as interpreted by necessity for protein restriction and either neomycin or lactulose. Incapacitating postshunt encephalopathy developed in two patients who required recurrent hospitalizations for episodic coma and/or seizures. Both patients underwent total abdominal colectomy and ileorectal anastomosis with significant amelioration of encephalopathy. Such surgical treatment of postshunt encephalopathy is collectively reviewed; and the efficacy of colon exclusion in well-selected cases is reiterated.

Alcohol and the Motor Vehicle: A Social and Economic Dilemma. Leonard J. Weireter, MD, *Norfolk.*

The association of alcohol intoxication with motor vehicle accident mortality has fostered a growing public conscientiousness that has pushed for legislative reforms aimed at removing the intoxicated driver from the highway. An article in 1984 (Maull et al. JAMA 1984;252:1880-3) reported that no DUI (driving under the influence) convictions in a cohort of 56 intoxicated drivers admitted to a university hospital trauma service. We investigated the legal fate of, and expense incurred by, intoxicated drivers (blood alcohol level greater than or equal to 0.10%) admitted to our trauma service between January and December of 1986 to see if hospitalization did offer a safe haven from prosecution. Police records of 34 patients were available for review. Eighteen (53%) were charged and 15 convicted. Thirteen were convicted of reckless driving and only two (6%) of DUI. These patients incurred an average hospital bill of $17,000. This population remains relatively immune to prosecution and is not effectively removed from the highway while consuming substantial health care resources.

Craniofacial Resection for Tumors Involving the Skull Base. James P. Neifeld, MD, Harold F. Young, MD, and Austin I. Mehrhof, Jr., MD, *Richmond.*

Tumors involving the skull base are difficult to manage and have high local recurrence rates and poor survivals when they do recur. Traditional management has involved surgery, radiation, or surgery followed by radiation. Using a multidisciplinary approach (surgical oncology, neurosurgery and plastic surgery) we have attempted to aggressively resect and reconstruct these patients. During a 9-year period, 41 patients underwent 43 combined intracranial-extracranial resections of tumors involving the skull base. The age range was 31 to 85. Diagnoses included paranasal sinus cancer (12 patients), skin cancer (17 patients), and a wide variety of other tumors, including 3 benign tumors. Most patients had undergone previous radiation and/or surgery (up to 35 previous operations). There were 12 temporal bone resections and 31 resections that included the floor of the anterior cranial fossa. Seven patients died prior to discharge: three patients had major vessel involvement resulting in severe neurologic impairment and subsequent death, one died from pneumonia, one from meningitis, and two from residual tumor. Other postoperative complications were minimal. Postoperative management included prosthetic rehabilitation, speech, and occupational therapy. Long term survival depended upon the underlying disease and if clear margins could be obtained. These data demonstrate that resection of tu-

mors involving the skull base can be performed with reasonable safety and long term survival. Better techniques for resection and reconstruction are resulting in better operative and long-term results.

The Influence of Preoperative Radiation Therapy on Morbidity and Mortality for Transhiatal Esophagectomy. Curtis G. Tribble, MD, Michael C. Murphy, MD, Thomas M. Daniel, MD, and Irving L. Kron, MD, *Charlottesville*.

Radiation therapy (RT) has been used preoperatively to prevent local recurrence following esophagectomy. The morbidity of preoperative radiation therapy has not been well studied. We reviewed 37 patients who underwent transhiatal esophagectomy at the University of Virginia between 1982 and 1987 for carcinoma of the esophagus. Twelve patients received no RT, 13 patients received RT only to the neck, 12 received radiation therapy to the chest (three of these received radiation therapy to the chest and neck). The patients were studied for mortality and morbidity. Comparisons between more than two groups of ordinal data were done by analysis of variance, and comparisons between groups of nominal data were done by two tailed chi-square tests.

Preoperative chest RT did not significantly increase intraoperative blood loss or postoperative fistula formation, but did lead to significantly higher operative mortality, overall complications, and time on ventilators than either the patients receiving neck RT alone or no RT. Postoperative hospital stay was longer for the chest RT group compared to those with no RT. Neck RT did not result in these complications. We conclude that preoperative chest RT leads to an excessive complication rate. Its use would have to be justified by the demonstration of significantly increased long-term survival for esophageal carcinoma when preoperative RT is used.

	Any Chest RT	Only Neck RT	No RT
n	12	13	12
Mortality	4*	0	0
Average Blood Loss (units)	4.1	2.9	2.4
Fistulae	4	5	2
Other Complications	10*	5	5
Ventilator Time (days)	3.3*	1.5	1.8
Postop Hospitalization (weeks)	3.2†	2.8	2.3

* $p < 0.05$: chest RT versus all others.
† $p < 0.05$: chest RT versus no RT

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VIRGINIA MEDICAL

EDITORIAL

Education–or Lack of It

EDUCATION in the United States must be lagging in all areas. In the February 10, 1989, edition of *AMA News*, this headline appeared: "AMA calls for action to 'turn tide' of low science skills." The article dealing with the subject refers to an informational report by the Council on Scientific Affairs that calls attention to the poor performance of US students in the sciences. American high school students take fewer courses in mathematics and science than do students in other developed countries and US students 14 years of age ranked 14th of 17 countries in their knowledge of basic sciences.

And all the time we thought the deficiency was in the liberal arts.

E. L. K., JR.

Horse, Knife, Wife

YOU can find a proverb to support almost any idea or position without having to state your position rationally, without having to state the alternatives, without having to think very hard. Some people use the Bible in this way, but I prefer proverbs.

However, sometimes a proverb does lend itself to analysis and introspection. I particularly like the Spanish (I think) proverb that states, Every man needs a horse, a knife and a wife, for its potential variations, as follows:

1. Every man needs a fast horse, a sharp knife and a good wife.
2. Every man needs a fast horse, a good knife and a sharp wife.
3. Every man needs a good horse, a sharp knife and a fast wife.

Interestingly, all three adjectives in this proverb can apply only to the wife, and more specifically I can apply all three to my wife. It takes more than good to raise three daughters and to tolerate for 28 years my rare peculiarities. Mentally sharp describes her well, and when the occasion demands, her appearance is as sharp as sharp can be. No one is faster at picking beans, finding my errors, forgiving my faults, and loving me.

Now that our children have finished college and are not living with us, we occasionally get a little bored with our quiet house. To enliven our lives we may quibble loudly and at length over matters of no consequence so that we can later have the pleasure of making up. Our children do not understand that this is not fighting and is not bickering but is another facet of our love and understanding.

After many years of marriage you communicate without verbalizing, almost by mental telepathy. The more deeply you are in love, the easier it is to read each other's thoughts. Sometimes you may mistakenly assume that your spouse knows your every thought when that is not possible.

Recently when my wife was seriously ill, with fluid about heart and lungs, with pain and with fever, I could hardly leave her bedside and camped in the hospital. I thought about our many years together, our three lovely daughters, our good fortune at having found each other. I was afraid for her and for me. As she improved and as her health returned, I was never happier. My love for her was even deeper than I had thought.

Some day I am going to tell her all of this.

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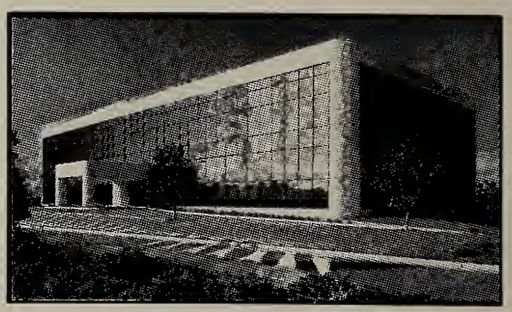

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POINT OF VIEW

Nursing Shortage: "The key is to move ahead"

The numbers are staggering: 80% of US hospitals report a nursing shortage, an estimated deficit of 300,000 nurses. Yet the numbers are only part of the story. We all know the rest. Overworked nurses burn out and leave the profession. Patients wait and wait for the bedside care they need to recover. And the situation worsens.

If the nursing shortage were only a nursing problem, perhaps, we could turn our heads and wait for organized nursing to propose an innovative solution for the short term as well as the long term. But it's not just a nursing problem. It's a patient care problem. And as patient advocates, we must respond.

In that spirit, the American Medical Association proposed a new category of caregiver, the registered care technologist. The AMA House of Delegates initially approved the RCT proposal at its June 1988 meeting. In December, the House approved plans for implementing pilot projects to test the RCT concept. The goal is to evaluate how effectively RCTs can provide the task-oriented care needed in hospitals and long-term care facilities.

The idea of a non-nurse working as a caregiver is not new. The military has had corpsmen working side by side with nurses in its hospitals for decades. Since June, a number of hospitals have informed us about programs similar in many respects which have been initiated at the local level.

Is the registered care technologist a sound idea? Only time will tell. Without testing the concept in a pilot project setting, we will never know. Meanwhile, the proposal has met with misunderstanding and dissent. Many see it as a turf battle between physicians and nurses. This is far from the truth. A turf battle occurs when two organizations compete to capture a common market (usually for financial gains). Medicine has no financial interest in nursing services. The RCT proposal is and will continue to be a substantial negative item in the AMA budget. This is a patient care issue.

The AMA is a long-standing supporter of organized nursing's call for increased salaries. However, these measures alone will not solve the shortage, not in the face of declining nursing school enrollments and hospital budget problems. If every nursing school in the country were filled to capacity, relief would still be four years away and would fall short even then.

Our patients simply can't wait that long.

Many detractors fear another caregiver at the bedside will compromise continuity of care. Again, the detractors are wrong. The RCT is intended to be a resource for nurses, serving as an extra pair of skilled hands. The RCT is *not* a substitute for nurses. Providing basic bedside care would be within the limited scope of RCT practice. Yet nurses would continue to assess patients' needs. The unit manager or charge nurse would monitor RCT performance.

Training is a very essential part of the RCT proposal. Plans are to provide instruction at three levels of competence: assistant (two months of training); basic (seven months); and advanced RCT (an additional nine months). RCT programs would be hospital-based and nurses would be an essential part of a multidisciplinary training team. RCTs would be eligible for certification as a basic RCT after their first nine months of training. The certification process would further guarantee minimal practice standards. Trainees completing the advanced level could qualify for certification as advanced RCTs.

What would RCTs do? At the assistant level, RCTs might be responsible for patient transport, simple wound care, bathing, and administration of enemas. Basic RCTs might *check* placement of nasogastric tubes, pass oral medications under supervision, and enter patient information in the unit computer. Advanced training would prepare RCTs to monitor IV infusions, administer routine IV medications under supervision, and recognize changes in patient status.

Some detractors have bristled at the idea of technicians providing patient care. This is not the first time. Over recent decades, respiratory technicians, cardiac technicians, emergency medical technicians, and

many others have filled necessary patient care roles. Some were met with initial resistance. Yet, in time, they earned the respect of their peers as integral members of the health care team.

RCT programs would not compete with nursing schools for applicants. In fact, the AMA believes RCTs could provide a pool for future nurses. Many high school graduates are interested in health care careers yet cannot afford four years of college. RCTs would be trained as apprentices on an earn-while-you-learn basis. Given this opportunity, many more people may choose health care careers who could not otherwise do so.

Many detractors have overlooked major endorsements of the RCT proposal. The National Association of Practical Nurse Education and Service, the largest organization representing licensed practical nurses, endorsed the program before it was presented to the AMA House of Delegates. In addition, nine state medical societies have endorsed the concept. Hospitals and other institutions in 20 states have asked to play a role in RCT pilot projects. These groups recognize that the idea deserves to be tested.

I am not writing this to support RCTs. The proposal is, after all, only a proposal. It must be tested and evaluated through pilot projects. Only then can its worth be judged. I am writing to support a concerted effort to solve the nursing shortage. Working together as patient advocates, we can find the answer. Divided, the shortage will only worsen and the quality of health care will slip between our fingers.

The AMA continues its dialogue with the various segments of organized nursing. We are not focusing only on the RCT. For the past year, the AMA has also looked at projects already in place which are similar to the RCT. As directed last December by the House, the AMA staff will continue to look at all the options. We welcome ideas from responsible organizations to improve the RCT proposal. And we would welcome other plans that could answer both immediate and future needs. The key is to move ahead with possible solutions.

To paraphrase an old adage, the AMA has chosen to light a candle rather than curse the darkness. The outcome of the pilot projects will serve to judge whether we have selected the right candle. But, at least, we are not sitting idly in the darkness while our patients wait for the bedside care they deserve.

WILLIAM S. HOTCHKISS, MD

Dr. Hotchkiss is a past president of both The Medical Society of Virginia and the American Medical Association. He may be addressed at the office where he practices thoracic surgery, 2147 Old Greenbrier Road, Chesapeake, VA 23320.

OBITUARY

Memoir of Munford Yates 1909–1988

By James D. Mason, Jr., MD

Dr. Munford R. Yates was born in Lynchburg, Virginia, on December 14, 1909. He died in Petersburg, Virginia, on June 20, 1988.

"Munny" attended public schools in Lynchburg before going to the University of Virginia, where he received his premedical, medical, and post graduate medical education. While there he was elected to membership in the Raven Society and also Alpha Omega Alpha. He married Frances Jones while in Charlottesville and in 1932 they moved to Princeton, New Jersey, to practice internal medicine. In 1933 they moved to Petersburg, where Munny entered practice with his fatherinlaw, Dr. Bolling Jones. In these early years Munny had the only EKG in town and frequently took his own EKGs in patients' homes.

In 1942 Munny entered the US Army and served three years in an army hospital in Iran. He returned to his practice in Petersburg in 1946 and practiced for 40 years before his retirement. His talents were recognized by his fellow physicians and he served the medical community as chief of staff of the Petersburg General Hospital, president of the Petersburg Medical Faculty, and president of the Fourth District Medical Society.

He was a faithful communicant of Christ and Grace Church; enjoyed working in his yard on Wednesday afternoons; played a good game of bridge; and in later years became a fairly avid stamp collector. But most of all he cared for people and especially for his family and for his patients. He had the wonderful ability to listen to people and he inspired confidence in his patients. His gentle nature and patience belied his mental brilliance and calm wisdom.

Munny is survived by his wife, four children, 17 grandchildren, two great-grandchildren and two brothers. His most important legacy to them and to us, his colleagues and friends, is that of an extraordinarily beneficent life as husband, father, grandfather, brother, friend and physician. We shall miss him but our lives are richer for having known him.

From one who was privileged to practice with him for 30 years and who admired him tremendously, I can best describe my regard for him by saying that knowing him has given me faith in the future of our profession. Few people have more opportunities to

influence peoples' lives than physicians. It is certainly true that Munny Yates influenced thousands of lives for good and I feel fortunate to have been one of them.

• **Lloyd Byron Burk, Jr., MD,** past president of the Arlington County Medical Society; University of Virginia School of Medicine, 1942; age 72; died March 24, 1989. He had lived in Locust Grove since retiring from his surgical practice in 1982.

• **Louise Leland Clark, MD,** longtime general practitioner in Chester; Medical College of Virginia, 1937; age 81; died March 11, 1989.

• **James A. Kitterman, MD,** Norfolk surgeon who was Third Vice President of The Medical Society of Virginia 1973-74 and president of the Norfolk Academy of Medicine 1977-78; University of Virginia School of Medicine, 1940; age 72; died February 14, 1989.

• **Donald C. McCollum, MD,** Ashville, North Carolina; George Washington University School of Medicine, 1935; age 81; died February 24, 1989. He practiced obstetrics/gynecology for many years in Arlington.

• **L. Benjamin Sheppard, MD,** longtime Richmond ophthalmologist and medical historian; University of Virginia School of Medicine, 1930; age 83; died March 8, 1989. He retired from practice in 1987.

• **Charles Edward Troland, MD,** Richmond neurosurgeon; Johns Hopkins University School of Medicine, 1936; age 77; died February 28, 1989.

• **Grover Robert Tompkins, MD,** internist in Newport News; West Virginia University School of Medicine, 1963; age 51; died July 18, 1988.

News of the death of a Medical Society of Virginia member may appear in these pages in either or both of two ways: 1) a brief notice written by staff giving factual information; 2) a memoir contributed by a physician who knew the deceased peer and writes a personal account of his or her life. If the memoir is contributed before the brief notice is inserted, it is published at once; if after, it is set in type to be published as space permits.

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WHO'S WHO

There was a big to-do in Norfolk to celebrate the arrival early this year of the 500th baby born under the auspices of the Jones Institute for Reproductive Medicine at Eastern Virginia Medical School. At a reception featuring a huge birthday cake covered with candles, **Drs. Howard and Georgeanna Jones,** the husband and wife team who pioneered the in vitro fertilization program at EVMS, introduced baby Nicholas Dana, born of a cryopreserved fertilized egg. His twin brother, born 18 months earlier, was the Institute's 316th test-tube baby. It will be necessary to redefine the word 'twins' in the medical dictionaries," Dr. Howard Jones observed to the reporters and photographers crowded around to record yet another landmark in the program that has put Virginia on the international medical map.

A month later the Joneses were saluted by Norfolk's Cosmopolitan Club as Norfolk's "First Citizens of 1988." Presentation of a plaque (one to share) and Distinguished Service Medals (one for each) was made at a big banquet at the Omni Hotel, for which Norfolk bigwigs (but no babies) turned out in black tie. This was the first time since its inception in 1928 that the club has named co-recipients for the annual award.

Pediatrician **Gayle G. Arnold, MD,** veteran activist on behalf of Richmond's cerebral palsied children, is to be installed in October as the 43rd president of the American Academy for Cerebral Palsy and Developmental Medicine. The installation is to occur at the Academy's annual meeting in San Francisco.

For 36 years Dr. Arnold has been medical director of the Richmond Cerebral Palsy Center, and for more than a decade he has served on the board of directors of the AACPDM, whose central office is headquartered in Richmond. The Academy has a roster of over 1,500 members—peers of Dr. Arnold in pediatrics, orthopedics, neurology, and physiatry, as well as therapists and other ancillary professionals.

Continuing the list in the March issue, here are more new component medical society officers:

Fauquier County Medical Society, **Dr. David E. Couk,** president, and **Dr. Margaret N. Jeffries,** secretary.

Halifax County Medical Society, **Dr. W. Joseph Ferguson,** president. **Dr. Paul S. Buckman** was reelected secretary.

Mid-Tidewater Medical Society: **Dr. Todd W. Geisert,** president. **Dr. Arthur J. Martin** was reelected secretary.

Newport News Medical Society, **Dr. James A. Wassum,** president, and **Dr. Frederick L. Robinson II,** secretary.

Patrick Henry Medical Society, **Dr. W. Daniel Prince III** (not Price, as printed in the March issue), president, and **Dr. G. Samuel Hurt,** secretary.

Williamsburg-James City County Medical Society, **Dr. Martin A. Thiel,** president, and **Dr. John C. Mincks,** secretary.

Dr. Lewis W. Bridgforth was the person chosen by the Victoria, Virginia, Chamber of Commerce for the 1989 installment of its Citizen of the Year Award. The award was presented during the Chamber's annual dinner meeting, with Chamber secretary and town manager Gordon Erby doing the honors. He described the general practitioner as "an outstanding individual . . . . warm, compassionate, and a friend to all," according to a report in the *Kenbridge-Victoria Dispatch,* and cited his untiring service over the years "without regard for his own personal needs or the thought of a 40-hour week." A native of Crewe, Dr. Bridgforth established his medical practice in Victoria in 1966 after graduation from the Medical College of Virginia. He was president in 1985 of the Southside Medical Society.

New president of the medical staff of Stonewall Jackson Hospital in Lexington is **Dr. James R. Crews.**

At the Shenandoah County Memorial Hospital in Woodstock, **Dr. Mark A. Rhodes** has been elected president of the medical staff.

Dr. Sterling N. Ransone, Mathews, who underwent cardiac surgery last September, retired in February after 33 years of looking after the people of Mathews County. He has made excellent postoperative progress, but "there comes a time when you just have to step aside," he told a reporter for the *Gloucester-Mathews Gazette-Journal.*

A native of Roanoke, Dr. Ransone received his doctorate in medicine in 1956 from the Medical College of Virginia, where a son, Sterling Ransone, Jr., is now a first-year medical student, and began practicing in Mathews the following year. He was president of the Mid-Tidewater Medical Society in 1964, racked up 20 years as a county medical examiner, served as sideline physician for the Mathews High School football team, and in 1986 received from the Mathews Junior Woman's Club its Outstanding Community Service Award.

Dr. Jack B. Perlmutter, Culpeper, was inducted as a fellow of the American Academy of Orthopaedic Surgeons during its recent annual meeting in Las Vegas.

Dr. James Michael Bestler, MD, Martinsville, was a speaker at the recent 1989 Southern Region Scientific Program of the American Academy of Facial Plastic and Reconstructive Surgery in Naples, Florida. His topic: "Lower Lid Blepharoplasty."

VIRGINIA MEDICAL

June 1989, Volume 116, Number 6

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surgeons in the operating room, the primary care physician, the anesthesiologist and the hospital.

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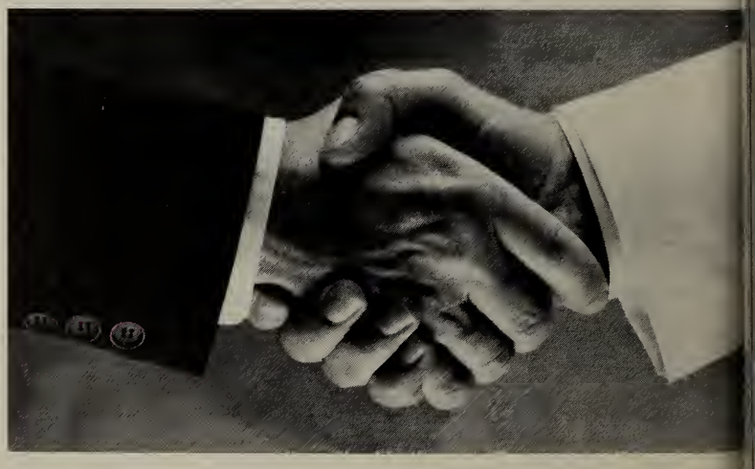

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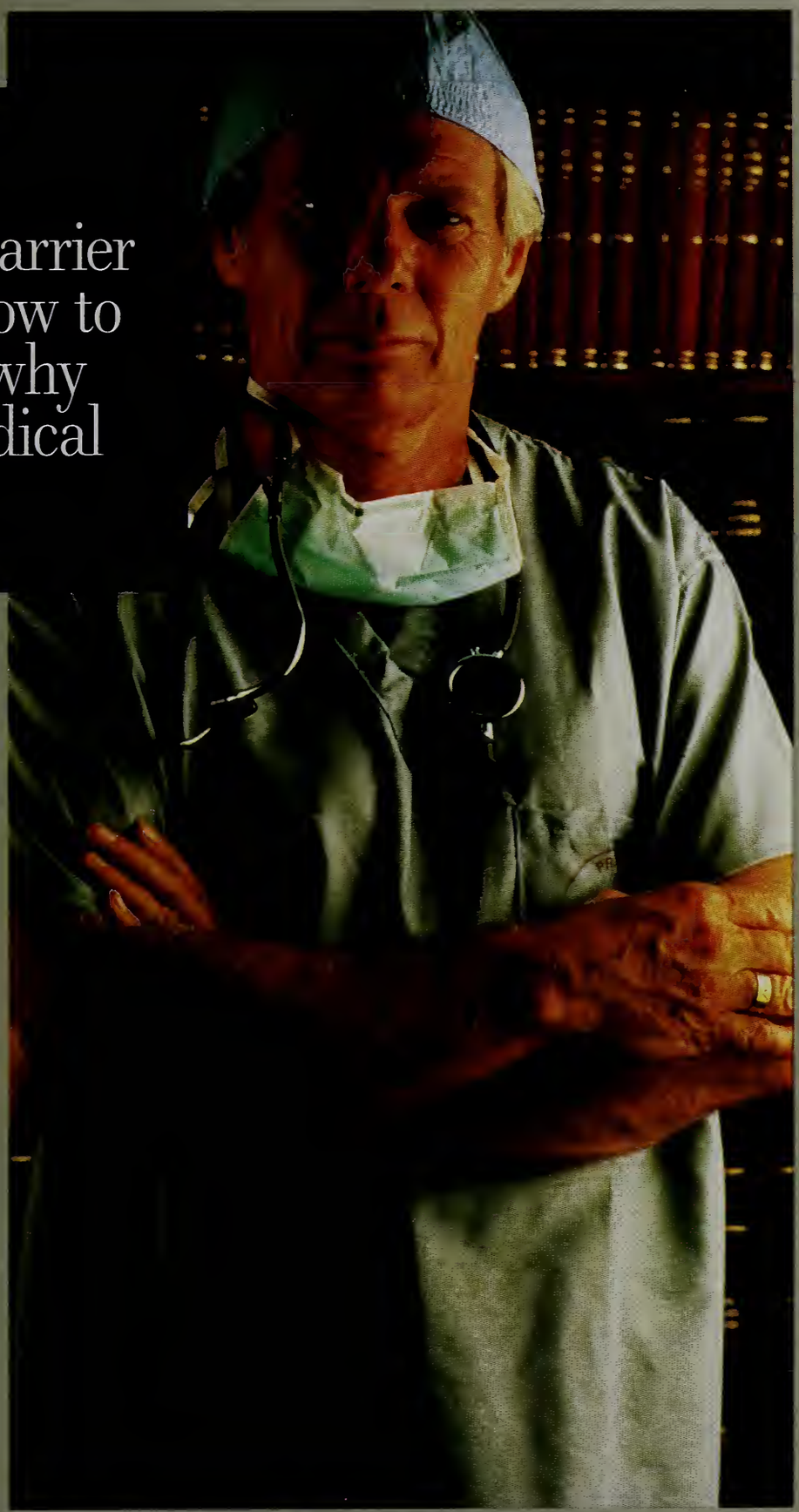

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LETTERS

Letter on complication secondary to ACE inhibitors prompts a query

I enjoyed reading the letter in the April issue describing angioedema secondary to hypertension medications.[1] I am curious to know: What was the delay between the angioneurotic edema and the onset of therapy? My thanks for bringing this to our attention.

Charles L. Baird, Jr., MD
Virginia Heart Institute
205 North Hamilton Street, Richmond VA 23221

1. Barna JS, Frable MAS, Abedi E. Report angioedema secondary to hypertension medications (letter). Va Med 1989; 116:147

The authors reply: We are glad Dr. Baird raised this question. The delay between the angioneurotic edema and the onset of therapy was as follows: For the four patients with angioneurotic edema secondary to enalopril, 3 days, 3 weeks, one month and 5 months. For the two patients receiving captopril, the onset of symptoms occurred at 10 days and one month. We have recently treated a patient with marked angioedema of the tongue who had been on enalopril for approximately one year. It has been our experience that a delay in onset of angioedema secondary to ACE inhibitors is the rule rather than the exception and that this complication can arise at any time during therapy. It is our belief that this complication of ACE inhibitors is more common than appreciated and is largely unrecognized because of the absence of temporal correlation between onset of therapy and angioedema.

Questions views expressed in article on health insurance

The Point of View entry from Drs. Clancy and Boling in the April issue[1] is disturbing. They state—20% of Virginians are "underinsured". In my practice, at least 50% of those "underinsured" have chosen not to pay insurance premiums through their jobs. Do we have a responsibility for those individuals?

Drs. Clancy and Boling know as well as we that the majority of costs of medicine have gone to technological advances and the care of the elderly. Their statistics on percentage of total health care dollars are in conflict with a concurrent series of articles in the American Medical News.[2]

Have these two academic physicians spent any time in Canada working and observing the Canadian sys-

tem? Why are the physicians in Canada anxious to come to the United States to practice? Why are there long waiting lines for open heart surgery, elective surgery, and even emergency admissions to hospitals in Canada?

They state that physicians want a NHP because they are unhappy with paperwork. If we teach physicians to be business persons they will not have to spend more time on paperwork. I would like to know where the 56% of physicians that support a national health plan are practicing.

Finally, the Canadians are sending representatives to our country to observe and evaluate our system of medical care. They would not be doing this if they have not recognized the severe restrictions and problems of their system.

The system in the United States is not perfect. Rather than change it, let's get together to improve the system. Numerous suggestions have been made, the best of which may be to have the federal government mandate compulsary health insurance for all employees. With a national unemployment rate of 5-6% there would be no need to completely overhaul our system. The savings in bureaucratic costs could be used to fund coverage for the uninsured and our present leadership in the medical world would be continued.

Charles J. Gueriera, MD
Suite 206, 9001 Digges Road
Manassas VA 22110

1. Clancy CM, Boling PA. Point of view: More for less. Va Med 1989;116:185
2. Page L. Medicine looks abroad. The Canadian solution? American Medical News, April 7, 14 and 21, 1989

The authors reply:

• We obtained figures for the number of uninsured and "underinsured" Virginians from the (State) Senate Finance Committee. While some individuals choose not to purchase insurance through their employers, 35% of small businesses in this state offer no health coverage whatsoever.

• The recent Harris poll confirms many previous surveys in finding that most Americans would prefer a Canadian system to ours. Also, medicine remains a prestigious occupation in Canada: there are more applicants for available spots in Canadian medical schools than in the U.S.

• The paper work we referred to is a direct result of labyrinthine processes to control costs. Despite an evergrowing bureaucracy, in the 1980s costs have escalated, while access to care has actually declined. Patchwork reforms have failed to break this cycle.

A Canadian system may not be ideal for this country, but we should note that neither Western European countries nor Canada have solved the problem of spiraling costs without implementing universal access. Finally, close scrutiny of other countries should expand our concept of what's possible.

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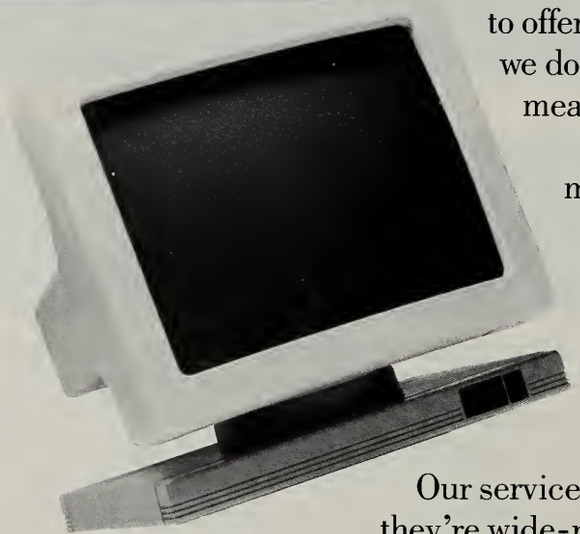

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MEDIBYTES

NEWS FROM VA MED'S COMPUTER ROOM

UNIFICATION, DUES ABRAID SURVEY RESPONDENTS

No doubt about it, Virginia physicians are feeling an acute need to express themselves on a range of perceived abrasions. That is abundantly demonstrated by the Medical Society of Virginia's recent statewide survey. The volume of responses alone is telling: Of 11,937 Physician Opinion Survey forms mailed out, 5,443 forms were filled in and returned, for a rousing response rate of 45.6%

Then there are the emotionally charged comments handwritten across page after page of the returned surveys. The doctors who wrote these comments do not mince words. Their language is harsh; praise is rare. This is true whether the respondent is an MSV/AMA member or not. Unification seems to be the biggest beef in the comments of responding members, the cost of dues the commonest complaint of nonmembers.

At Medical Society of Virginia headquarters these comments are being carefully studied and organized, with the intention of publishing a representative collection of them in a coming issue of Virginia Medical.

COUNCIL HEARS SURVEY DATA

Meantime, the survey forms that had been returned as of February 27 were sent on to AMA headquarters in Chicago for tabulation by the AMA's big data banks,.and when the MSV Council held its quarterly meeting at Richmond headquarters in April, President J. Thomas Hulvey led off the agenda by calling for the results of that tabulation. Ready with the data was Tom Everding of the AMA Membership Benefits and Research staff.

Of the 4,037 respondents whose returns had been tabulated, Everding began, 2,329 (58%) professed to be MSV/AMA members, 1,600 (40%) described themselves as nonmembers, and 107 (2%) did not answer that question.

Overall, Everding said, the respondents were troubled most by unification, the cost of dues, and a perceived lack of membership benefits. These and other problems seem to be aggravated by inadequate communication. What the respondents were saying, he told the councilors, is that "dues are too expensive for what they get, and they're not sure what they get."

Everding then proceeded to give some results for each of the survey's categories of concern. The handwritten comments described above were not "read" by the machines and therefore do not figure in Everding's report.

Image of Physicians: The general public views physicians today with

less respect then it did five years ago, said 71% of the respondents. Only 1% registered the opposite view, according to Everding.

Need for Organized Medicine: By an overwhelming 74%, Everding related, the respondents feel there is more need for organized medicine now than there was five years ago. Over 80% of members and 63% of nonmembers expressed this opinion.

As to organized medicine's effectiveness, 45% of the respondents feel it is less effective than in the past, with nonmembers slightly more likely than members to hold this view.

Medical Society Emphasis: In general, reported Everding, the respondents want greater emphasis by medical societies on 1) state/federal government involvement in health care; 2) relationships with Medicare, Medicaid, and third-party payers; 3) medical cost containment; and 4) professional liability issues.

As for the reasons the respondents gave for considering membership in a medical society, Everding's report gave first importance to the provision of continuing medical education and representation in state/federal government. Frequently tagged as "somewhat important," the tabulation indicated, were these reasons: provides socioeconomic/scientific publications; offers collegial contacts/shared interests, supports medical research and education, engaged in maintaining professional discipline.

Medical Society Involvement and Dues: According to Everding's figures, 594 of the responding 2,329 non members said they are component society members, and 1,270 professed specialty society membership.

Medical society involvement is highest in the specialty societies, the survey indicated, although even there it is usually "moderate." As for component societies, responses were almost evenly split between "not involved" and "moderately involved," and similarly low levels of involvement were indicated for both the AMA and the Medical Society of Virginia.

Everding next related responses to the question "How well informed do you consider yourself to be about MSV activities?" He tallied 11% of the respondents who feel well informed, 47% who feel "somewhat informed," and 40% who do not feel well informed.

To the question "Why aren't you an MSV/AMA member?," these reasons were evoked most often: unified membership; costly dues; and perceived lack of benefits. Also cited frequently was the feeling that organized medicine has been ineffective in representing medical concerns.

As for membership dues, 67% of all respondents reported they pay over $500 in membership dues each year, with 32% paying over $1,000, Everding told the councilors. As could be expected, those who are not MSV/AMA members pay lower amounts, with 61% falling in the $250-$1000 range.

Medical Society Image: The survey listed 15 words/phrases and asked

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Several members of the Physician Insurance Committee meeting recently included Eugene Overton, M.D., David Pariser, M.D., Robert W. Waddell, M.D., Stephen Irvin, M.D., Willette L. Lehew, M.D. and James Walsh, M.D.

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As Committee Member Emerson Farley M.D. puts it "We attempt to insure the best risks and that keeps our rates low. If we lose sight of that, we lose the ball game."

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the respondents to check those that seemed to best describe the Medical Society of Virginia today. "Traditional" was checked by 40% of the respondents, "conservative" by 39%, "run by a few" by 34%, and "professional" by 31%, Everding reported.

Of the 4,037 respondents, a total of 1,780 physicians, including 406 nonmembers, expressed the belief that Medical Society of Virginia membership is an aid in addressing concerns about medical practice.

Medical Society Recruitment: Of the responding nonmembers, 851 indicated they had never been approached to join the Medical Society of Virginia or did not know if they had been approached, according to Everding's data. The greatest percentage of physicians who had been approached said they prefer to be contacted by mail.

In conclusion, Everding told the councilors that "the survey's results overall are consistent with membership surveys conducted by other medical societies."

Dr. Hulvey resumed the agenda by noting that the survey data compiled by the AMA had been discussed the previous day at a joint meeting of the Membership, Executive, and Unification/Deunification Committees and asked for a report of that meeting. It was given by Dr. James L. Patterson and consisted of the following recommendations: 1) Reaffirm support of unification. 2) Mail a response to the survey to all Virginia physicians. 3) This third recommendation, offered separately by the Membership and Unification/Deunification Committees, advocated support for a major membership recruitment program by a) continuing current MSV staff efforts, b) initiating an AMA Outreach Program, and c) appropriating $5,000 for marketing consultants to develop "a total marketing program...with a target of 2,000 new members by the year 1991."

To describe the recommended Outreach Program, Dr. Hulvey recognized Dr. William S. Hotchkiss, Past President of both the Medical Society of Virginia and the AMA.

"The recruitment of new members is the responsibility of the leadership. We must endorse that," Dr. Hotchkiss said in preface. He was talking about personal recruiting, he continued, and the Outreach Program would provide a comprehensive how-to guidebook and a list of nonmembers to be solicited one-on-one by each of the Society's officers and councilors in their respective communities. There would also be a sequence of mailings, he said, formulated by the AMA's experienced recruiting staff.

Dr. Hulvey then opened the meeting for discussion, and a long and vigorous discussion it was. Among the first to speak was Dr. William H. Barney, whose message was in three parts, as follows:

1) "Our first responsibility is to the Society. If we don't stop this financial hemorrhaging, there won't be an MSV by 1991."

2) "This survey is important. The respondents are telling us there are a lot of dissatisfactions out there. I think unified membership is first on the list."

continued on page 265

3) "I think they're also telling us to restructure the Society's benefits program. Before we start an Outreach Program, we should say, 'We heard you, and we're going to take action,'" Dr. Barney concluded.

Dr. H. C. Alexander rose to agree to a need for restructuring and "a change in our priorities." Dr. Ira J. Green supported Dr. Barney's opinion that changes should be made consistent with the survey's results "before we go back to another recruitment program." He also advocated hiring marketing experts, as did Dr. James A. Shield, Jr., who urged, "Get an expert. Tell him to look at this organization exactly as you look at a patient—buck naked and honest. Get a treatment plan. It's a chronic disease."

Immediate Past President Glenn B. Updike begged to differ. "We can't sit around here waiting for a two-year study. The problem is *urgent*," he said emphatically, and he asked that the Outreach Program get into gear at once and a report of its results be made four months hence at the Council's September meeting "so that unification/deunification can be addressed."

There upon the Council voted:

No to reaffirmation of unification.

Yes to mailing a response to the survey to all Virginia physicians. (Selected for the mailing: a reprint of Dr. Hulvey's page titled "We asked what you thought—and you told us" in Va Med's May issue.)

Yes to continuing MSV staff recruiting efforts.

Yes to the Outreach Program, with the timetable suggested by Dr. Updike.

Yes to $5,000 for a professional marketing effort.

The "financial hemorrhaging" referred to by Dr. Barney was then reviewed by Dr. Charles M. Caravati, Jr., on behalf of the Finance Committee. The auditors had been called in for a special midyear audit, he told the councilors, and had found that the Society is being "very prudently managed" by Executive Vice President James L. Moore, Jr.

But the financial outlook for 1989 is not good and may get worse, Dr. Caravati warned. As of that date, some 700 MSV/AMA members had not paid their dues for 1989, he revealed, and in his opinion "we're not likely to get more than half of them." Thus he forecast a fiscal shortfall this year of $200,000-$250,000, for which, he said, "we'll have to dip into the reserves again, taking them down to around $1 million."

"We've either got to find more members or decrease expenses," he concluded. --A.G.

ELEVEN VMAPP SIGNUPS: Due to a printer's error, the Medibytes section in the May issue carried a report that three component medical societies had signed up for the Voluntary Medicare Assignment Program for Physicians, when in fact eleven societies are now participating. More on this in a later issue.

VIRGINIA MEDICAL
JUNE 1989

Portrait of an Impaired Physician

"I wanted to kill you," John told the interveners who had coaxed him into treatment, "but now I wish you had come to see me sooner."

by David G. Fluharty, Jr., MD

Since its inception five years ago, The Medical Society of Virginia's Impaired Physician Program has evaluated 140 physicians. Of these, 60 have completed treatment and aftercare monitoring, and 80 are being followed. Who are these physicians? the Editors asked Dr. David G. Fluharty, Jr., the program's medical director. What are they like? How about some case reports?

The program's confidentiality prevented him from divulging any identifying information, Dr. Fluharty replied. He could say, however, that within the Virginia program's experience, impaired physicians fall into two distinct age groups. About a quarter of them are 28 years old ± a few years; these younger doctors usually are dysfunctional due to "hard" drugs. The remaining three-quarters are 42 years old ± a few years; in this group impairment is due most often to alcoholism.

As for case reports, Dr. Fluharty continued, the program's compelling experience is that one case is pretty much like another, so similar are the historical patterns of birth, background, and behavior. To illustrate, he drew the following composite picture of an impaired physician in the larger, older, alcoholic group.

JOHN, Jr., the son of a physician, remembers feeling unacceptably different from others during his early childhood. Somehow he never felt quite as good as others, despite his superior intelligence, good looks and pleasing, if somewhat reticent, personality.

His father was a hardworking physician who was rarely at home. He was terribly perfectionistic and was given to pointing out to John deficiencies that made his son less than perfect. John felt he had something to prove; his personality became subverted to this need and he became as a consequence very competitive. At the age of 30 he played pingpong with his 8-year-old daughter and beat her 50 sets in a row—nobody ever beat John! Although aggressive and quite hostile, he was at the same time a people-pleaser, taking care to avoid offending. This made it difficult for him to say No; he belonged, for instance, to a wide variety of professional and social organizations simply because he felt compelled to agree to join when asked.

John yearned for the compliments he did not receive at home but could not believe them when they were

offered. When someone said, "You're really sharp today," he would wonder, What do they want? Why was he nice to me? Or he would put down the compliment by saying, "Yeah, not bad for a real jerk."

John kept people at a distance, fearing that if they knew him they would not like him. He had many acquaintances but no true friends with whom he could share his successes and his mistakes.

Although he worked very hard and was regarded as bright by everybody, John justified his sensation of inferiority by believing only bad things about himself. He could not stand making mistakes.

The combination of innate intelligence, perfectionistic drive, and sensitivity made him an ideal college and medical student. He graduated cum laude, tenth in his class—an AOC. His surgical residency was very competitive, which tended to reinforce his need for isolation from others. He never shared his fears or his inadequacies with another human being. Since mistakes separated the winners from the losers in his residency, his need to deny failure, deny mistakes was intensified. So was his lack of trust in others.

New post underscores program's success

Founded in 1982, the Medical Society of Virginia's Impaired Physicans Program has become a potent force in the identification and rehabilitation of Virginia doctors handicapped by drugs or emotional problems. The increasing significance of its work was underscored last month when the Society hired the program's first medical director. He is the internist/addictionologist who wrote the accompanying article, Dr. David G. Fluharty, Jr., of Newport News.

For the past three years Dr. Fluharty has been chairman of the program's parent organization, the Physicians' Health and Effectiveness Committee. To replace him, MSV President J. Thomas Hulvey appointed Dr. Carol S. Shapiro and Dr. William P. Arnold as cochairmen.

The committee's members are Dr. Owen W. Brodie, Dr. Robert M. Campbell, Dr. Milton Greenberg, Dr. Mark E. Holt, Jr., Dr. Lawrence K. Monahan, Dr. Lloyd F. Moss, Dr. John A. Owen, Jr., Dr. Basil E. Roebuck, Dr. Jeremy A. Stowell, Dr. J. Pat Tokarz, student A. Michael Deep, and, from the Auxiliary, Mrs. William J. Reardon and Mrs. Carolyn Moore. Special adviser to the committee is its founding chairman, Dr. William H. Barney.

His residency finished and his practice begun, John's restless drive to accomplish led him rapidly to preeminence in the professional community. Accomplishments gave him a fleeting sensation of well-being, and he expanded his interests beyong medicine, becoming chairman of the Opera Association and the local Red Cross chapter and president of the Rotary Club. His life was apparently an enormous success—although, in fact, it had been reduced to a frenzy of work.

The quality of John's life began to deteriorate, not only because nothing made him feel good but also because all he did was work, eat, and sleep. Finally John began to lose the quality that had always characterized his efforts. His performance in a number of areas began to slip, and while his peers and acquaintances at first made excuses for him, ultimately it began to be rumored that John was an unreliable performer. John, sensitive as always, was acutely aware of his deficiencies and tended to dwell incessantly on them. This caused him enormous remorse and consumed a great deal of his energy.

At the age of 42, John was unable to cope any longer with his imagined inferiority by overaccomplishing and overperforming, and he began trying to escape. At first he escaped psychologically by focusing with feverish intensity on collecting art.

John had always enjoyed alcohol. His natural tendency to isolated himself from others seemed to disappear when he imbided. As a young man he drank only a few drinks after work every day with friends, a drinking pattern very much like those of his peers. After he became an established surgeon he continued to drink nearly every evening. As the complexity of his life increased, he increased his use of alcohol, which gave him a sensation of peace and serenity his life did not otherwise afford him. Ultimately he began to drink while on call. Over a period of time he became more irascible, his relationship with his wife degenerated, his children became afraid of him, his peers began to avoid him, and, worst of all, John began to mistrust himself.

Patients he admitted were often forgotten. He could not remember telephone conversations or give appropriate orders to the nurses. He went to the emergency room some nights with alcohol on his breath, barely able to function. All this caused concern among his peers. He in turn felt terribly remorseful as he recognized his declining performance. A trial of self-administered tranquilizers afforded him little relief from the emotional pain of his situation.

Slowly, under the influence of alcohol, the unwarranted bad self-image of his childhood became valid. He withdrew, professionally, socially, and from his family. Ashamed of his performance, he isolated himself. His family avoided thinking his behavior was related to alcohol because they were sure such a charge would force him out of medicine and destroy his family financially. Actually, a financial disaster was in the making anyway as John stepped up his spending on his art collection.

Finally the administrator of the hospital, alerted to the problem by

emergency room and floor nurses, consulted with the chief of staff. They agreed that John was becoming impaired. The chief called the Impaired Physicians' Program at Medical Society of Virginia headquarters. He outlined the hospital's concerns, then documented the case in writing.

Within a week the program's medical director and a physician-intervener made a late afternoon appointment to see John in his office. They told him about the program, pointing out that it was charged with restoring to health those physicians whose practices were compromised for psychological or other reasons. They outlined their personal concerns about John. When John demanded to know who had reported him, they refused to tell him.

John told them he simply drank a few martinis in the evening and afterwards sipped along on Scotch. He added that he never drank too much and noted that he was nervous because his wife had been unpleasant to him and his children were having difficulties. He made excuses for his professional performance. He carefully avoided admitting to alcoholism. The interveners suggested to John that he be evaluated for chemical dependency. At first he vehemently refused, but when he learned that the alternative to voluntary evaluation would be a report to the Board of Medicine, he agreed to the evaluation.

At a treatment center specializing in the care of impaired physicians, John was evaluated both physically and emotionally by a psychologist, a specialist in addictive diseases, and an internist. The assessment team concluded that he was chemically dependent on alcohol and recommended inpatient treatment for a period of 30 days.

John went to a meeting with other recovering doctors. He told them he was not alcoholic and anyway, his

BOOKS

White Rabbit, a Doctor's Story of Her Addiction and Recovery, by Martha Morrison, MD. New York, Crown Publishers, 1989, 240 pages, $17.95.

The Jefferson Airplane's singer-songwriter Grace Slick created the inspiration for the title of the book with her allegorical song, "White Rabbit." In her song, Alice is a drug addict and the white rabbit is the disease of addiction. You will remember Lewis Carroll's tale of *Alice in Wonderland,* where Alice follows a white rabbit underground. There she has fantastic perceptual distortions and some relationships with unusual characters. One hundred years after Carroll's creation, Dr. Martha Morrison recreated the journey in reality, escaping with her life and faculties to tell the story.

At the age of 12, Dr. Morrison began consuming her mother's pain pills. At the age of 13, she was a blossoming alcoholic. Her craving for drugs and alcohol consumed her life except for one area, which was to study medicine. It was her association with the medical profession that ultimately saved her life.

Two physicians, "Ron" and "Harvey" made their first intervention on behalf of the Arkansas Medical Society at the home of Dr. Morrison. Ron confesses that he invented the term "Impaired Physician Committee" on the spot. The ordeal of these doctors at this showdown is tragicomical and is masterfully described. This chapter, entitled "Apocalypse Now", is a physician's adventure worth reading.

Revelations by Dr. Morrison are starkly honest and raw. A psychiatrist, she is equipped to portray human behavior and dynamics in a credible fashion. An example of her applied skills is her well-documented aspect of addicted people's problems with addicting relationships.

Dr. Morrison's literary style is lyric. Considerable scientific material, historical data and chronology is artfully mixed with philosophy, poetry and drama. Paragraphs submitted by witnesses to her life are interspersed throughout the story.

One can envision a starving female, center stage in the spotlight, tying off a vein. From the wings comes forward the cast of characters so prominent in Dr. Morrison's life. To name a few:

Doyle Morrison, benign father who could only love;

Eliene Morrison, desperate and worn mother;

Ed Morrison, big brother 11 years older, recovered from rheumatic fever and off to his own life, reclaiming his relationship with Martha at her recovery;

Brad Williams, alcoholic first husband, who cared enough to find help;

Connie Williams Kingston, Brad's sister and Martha's devoted friend;

Maggie Peters, well-meaning friend caught up in the confusion and still confused;

Paul, second husband, who is silent;

Sally Johnson Bergman, girlfriend for a lifetime, never involved but sadly observant;

Donnie Brown, rehab counselor, nerves of steel and unshakable faith, would have tried a different course;

G. Douglas Talbott, MD, recovering alcoholic internist, founder of Talbott Recovery System, Atlanta, visionary crusader for the addicted and Martha's devoted physician;

Doug Talbott, Jr., third husband, sober and romantic.

WHITE RABBIT

A Doctor's Story of Her Addiction and Recovery

Martha Morrison, M.D.

The observers often have conflicting views. Their commentary creates landscape for Dr. Morrison's imagery. The form of the book maintains reader interest and reflection.

The poetry is sometimes original with Dr. Morrison, sometimes from the masters. It tends to lend intensity to the suffering, which is often denied in the counterpoint from Dr. Morrison's diaries. The tempo is varied, with occasional recitations of drug lists and symptoms interspersed with narrative and medical reports.

The monetary investment in Dr. Morrison's treatment must be astronomical. Where did it come from and is it there for others? How Dr. Morrison managed to survive financially is worth knowing and is written in the chapter "Journey Without Destination."

One could dislike Dr. Morrison. She is a liar, thief, fraud and opportunist. She is adolescent, foulmouthed and wearisome. It is tempting to diagnose her with some heavy print from the DSM III-R on Axis II. So many of our patients try our patience to the point where we cannot endure. The wear and tear on family, physicians, hospital personnel and friends often snaps the therapeutic net and releases the addict to the streets again.

But there is beauty in the beast. Through her repugnant behavior emanates incredible sensitivity, courage, faith and intellect. How this miserable brain on drugs and in withdrawal functioned is a mystery. Victory is truly sweet with this lady. She works with intensity to treat young addicts now. Her commitment is ferocious and religious. The ultimate resource is divine assistance, which many of us call upon already. Few of us insist that our patients develop such consultation, however, as do the addictionologists. The addicted are so hard to "treat" that the "higher power" is required as a steady drip instead of in a bolus.

Reinhold Beibuhr's serenity prayer inspires us all and of course is included in Dr. Morrison's script. For physicians, the epigraph in her book speaks more powerfully. It speaks to the exhausted physician as well as the desperate patient. It speaks to the therapeutic alliance and the glorious victory of healing, the mystery of medicine which cannot be destroyed by the battering of political forces.

Epigraph:
For those who have fought
for it,
Freedom has a flavor the
protected have never known.
Anonymous

The book is for us and everyone else. Teenagers could read this with professional or family support. It is a convincing chronical that addiction is a disease of disgusting proportions and one that could be treated. Dr. Morrison is no Alice in Wonderland—but the rabbit is still in the grass.

ELOISE C. HAUN, MD

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patients needed him. He also told them his finances would be irretrievably damaged if he did not return home immediately. The doctors pointed out that they, too, had felt that way. They talked to him about how they had resolved their fears and concerns. Under the intense confrontation of his peers, John broke down and cried, finally admitting the unadmittable, that he was an alcoholic. He was supported with enormous quantities of love by the recovering doctors. For the first time in his life John began to feel that he was a part of something, that he was totally acceptable.

WHEN John returned home from treatment he established a contract with The Medical Society of Virginia to monitor his aftercare program. The contract included attendance at Alcoholics Anonymous meetings and occasional urine tests for alcohol and drugs. John understood that compliance with the Society's program would eliminate the need for the Society to report him to the Board of Medicine. He understood that there is an agreement between the Board and the Society sanctifying this arrangement.

From denial on discovery, John progressed to gratitude on recovery. "I wanted to kill you," he told the interveners who had persuaded him into treatment, "but now I wish you had come to see me sooner," and when he had completed the aftercare monitoring period, he volunteered as an intervener, too. Thus he joined a cadre of enthusiastic, recovering Virginia physicians whose practices, lives, and words testify to the benefits of this valuable program.

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Beer Potomania Syndrome in an Alcoholic

Arthur S. Harrow, MD
Highland Springs, Virginia

ALCOHOLISM has a depressingly high prevalence in the current population and frequently leads to metabolic derangements ranging from anæmia to ketoacidosis. There are many reasons, all of them well-recognized, that an alcoholic patient might present with hyponatræmia.[1–4] The following case report demonstrates an infrequently recognized cause of a low serum sodium in an alcoholic patient.

Case Report

A 47-year-old woman presented to the emergency room with anxiety and agitation. She had a history of chronic alcohol ingestion (exact substance unknown), with the last drink approximately 16 hours previously. In the emergency room a generalized tonic-clonic seizure was observed. There was no reported history of fever, head injury, prior medication or seizure disorder.

The initial physical exam revealed a patient who was alert and oriented. The temperature was 98.4° F orally with pulse 140 beats per minute, respirations 22 breaths per minute, and blood pressure 136/78 mm Hg. The examination was most remarkable for ecchymotic areas on the buttocks and tachycardia. The neurologic examination was normal.

Initial laboratory screening revealed a white blood count of 18,700 cells/ml with a differential of 72% segmented neutrophils, 4% band forms and 19% lymphocytes. The hemoglobin was 12.1 gm/dl with hematocrit of 35.3% and mean corpuscular volume of 96 femtoliters. The platelet count was 151,000/ml. The serum sodium was 123 meq/1 with potassium 3.0 meq/1, CO_2 20.8 meq/1, chloride 90.0 meq/1, BUN 7 mg/dl, creatinine 1.0 mg/dl and magnesium 1.0 meq/dl. The albumin was 3.9 g/dl. An arterial blood gas on ambient air revealed pH 7.50, P_ACO_2 26, and P_AO_2 47. Urine sodium was 83 meq/dl with a calculated fractional excretion of sodium of 3.62%. A chest roentgenogram showed no infiltrate.

The patient was admitted to the hospital and treated initially with 3% saline fortified with potassium, magnesium and vitamins. She was also treated with intravenous sodium penicillin G for presumed aspiration pneumonia. The following morning the serum sodium had risen to 127 meq/1 and the fluid was changed to isotonic saline. A nasogastric tube was inserted and enteral nutrition provided. The sodium increased to 135 meq/1 the following day. No cultures of blood or urine showed any growth, and she was discharged with normal electrolytes after normal feeding resumed.

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Submitted 3–9–89.

Discussion

The effects of alcohol ingestion on serum sodium levels have been well documented in the literature. Patients consuming alcohol are prone to volume contraction due to decreased sodium intake as well as the volume contraction caused by alcohol-induced diuresis. Alcohol has been shown to suppress antidiuretic hormone production.[1] Alcoholics are prone to infections, which may increase antidiuretic hormone levels. Thiamine deficiency has been reported to cause hyponatræmia in the alcoholic patient, associated with low urinary sodium levels.[2] Chronic alcohol ingestion has been shown to result in increased total body water, extracellular fluid and intravascular volume.[3]

There are several clear reasons why a patient such as the one presented above might have a low serum sodium. Her enhanced urinary sodium excretion would tend to exclude volume contraction and is not consistent with reports of hyponatræmia associated with thiamine deficiency.[2] Her abnormal blood gasses suggest the presence of pneumonitis, which might increase ADH levels (although laboratory data to include or exclude this was not performed). There is, however, another less well-recognized cause of hyponatræmia in the alcoholic which bears discussion: the syndrome of beer potomania.

The first specific report of "beer drinker's hyponatræmia" was in 1972.[4] A patient was described with recurrent symptomatic hyponatræmia. Evaluation revealed a serum sodium of 122 and urine specific gravity of 1.018; the albumin was normal. The only treatment consisted of placing the patient on a regular diet; serum sodium normalized without other interventions. The authors felt that this most likely represented the syndrome of inappropriate ADH secretion.

Five chronic alcoholic patients presenting with low sodium and potassium were reported in 1975.[5] These patients followed a similar course in that the laboratory abnormalities were corrected with minimal intervention except for hospitalization and adequate nutrition. At that time the data concerning ethanolic suppression of ADH secretion was available and SIADH was discarded as an explanation. A rather elegant hypothesis was proposed as follows:

These patients had been living almost exclusively on beer, a markedly hypotonic fluid. As a result, they had the combination of poor protein intake, poor sodium intake and water loading. This was thought to lead to loss of the urea-concentrating gradient, causing a loss of ability to excrete water. The sodium depletion led to

intense resorption of sodium in the distal tubule. enhancing potassium excretion (explaining the puzzling finding of hypokalæmia, since the particular beers in question were relatively potassium-rich). It was felt that this hypothesis explained the chemical abnormalities and their correction with nutritional support only.

In 1984 Kessler et al[6] reported a patient with the presentation of coma and hyponatræmia. She was treated successfully with isotonic saline. In hospital this patient was placed on a regimen of ten 16-oz cans of beer/day for a one-week period (≈4800 cc/day); no notation was made of the remainder of the diet. His sodium did fall from 135 to 122 meq/dl on this regimen. The possible causes were discussed, including hypovolemic stimulation of vasopressin overriding the vasopressin suppression known to be associated with ethanol.

The most recent literature report of beer potomania was in 1986,[7] where a patient was felt to have beer potomania based on history, hyponatræmia and a low urinary sodium concentration. This patient was treated with hypertonic saline with resolution of symptoms and chemical abnormalities. The importance of adequate nutrition in the prevention of recurrence was stressed.

Appropriate management lies in sodium replacement as described in previous reports. However, it is notable that several of the described patients had uneventful recoveries without the administration of hypertonic saline (with its attendant risks of congestive heart failure and central pontine myelinolysis), suggesting that this regimen (which is frequently recommended for symptomatic hyponatræmia) may not be necessary. The provision of adequate nutrition after discharge is certainly important in prevention of further episodes; the provision of adequate nutrition during hospitalization must not be overlooked. The patient placed "npo" while the mental status is decreased may acutally have prolonged morbidity in this setting.

Summary

To summarize, patients with the "beer potomania" syndrome are characterized by 1) a history of chronic alcohol ingestion (in a hypotonic form); 2) protein malnutrition; 3) signs, symptoms and laboratory values consistent with water intoxication, including hyponatræmia, hypochloræmia and, usually, hypokalæmia; 4) no evidence of another cause of hyponatræmia such as steroid use, diuretic use, hyperlipidæmia, etc.

The pathophysiology involves the inability to excrete sufficient free water, based on a loss of normal renal urea gradients. Patients may actually be total-body sodium depleted, yet have elevated urinary sodium and fractional sodium excretion due to this disorder of water metabolism. Attention to proper nutrition during the acute illness may obviate the need for potentially hazardous administration of hypertonic saline.

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Help for a troubled friend is only a phone call away.

If you suspect a colleague is experiencing problems with alcohol or drug abuse, don't contribute to the "conspiracy of silence," call The Medical Society of Virginia's Physicians' Health and Effectiveness Committee. A non-punitive approach through rehabilitation *is* an alternative. Your report will be kept confidential. Ask for Jeanne Douglas at MSV headquarters, (804) 353-2721.

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New Techniques in Diagnosing Malignancy: Morphology and Beyond

Michael J. Kornstein, MD, *Richmond, Virginia*

New pathologic techniques are improving the ability to detect malignancy and determine treatment modes. With immunohistochemistry the pathologist can make important distinctions, such as differentiating between carcinomas and lymphomas. With the flow cytometer various cell parameters and fluorescent labels can be measured. Still investigational are techniques for the detection of activated oncogenes and early viral infections.

Since Virchow first promulgated the art of tumor diagnosis by microscopy in the mid-1800's,[1] histopathology has been the basis for the diagnosis of malignancy. Indeed, much information can be obtained from the microscopic appearance of a tumor and morphology remains the gold standard in all aspects of tumor diagnosis.

Nevertheless, advances have been made in the understanding of malignancy and, correspondingly, new techniques are available which provide information supplementary to morphologic appearance. At the Medical College of Virginia, a laboratory within the Division of Surgical and Cytologic Pathology is using these new techniques in the daily task of providing accurate diagnostic and prognostic information for the benefit of the oncology patient.

The most established technique beyond morphologic examination is immunologic identification of tumor antigens or products in tissue sections ("immunohistochemistry").[2] Briefly, an antibody directed against a tumor marker, such as prostate specific antigen, is incubated on a section of tumor. A second antibody directed against the first antibody is then layered onto the section. This second antibody may be labeled with an enzyme, which, when provided with its substrate, produces a colored precipitate at the site of the antigen. Thus a metastatic, well-differentiated adenocarcinoma which expresses prostate specific antigen is almost certainly of prostate origin.

The substances which can be identified using this technique are numerous and limited only by the availability of antibodies and the stability of the antigens (Table 1). Among the most useful antibodies are those that distinguish carcinomas from lymphomas. This distinction is occasionally impossible on the basis of light microscopy. Yet lymphomas are treated much differently and often respond much better to therapy than carcinomas.

The immunohistochemical demonstration of cytokeratin within a tumor supports a diagnosis of carcinoma rather than lymphoma. Cytokeratin is a structural protein characteristic of epithelial cells and epithelial-derived tumors.[3] It can be identified within carcinomas and some sarcomas but has not been reported in

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lymphomas (Fig. 1). Similarly, another marker, leukocyte common antigen, identifies most lymphomas but is absent in carcinomas.[4] In selected cases, the use of immunohistochemistry improves the diagnostic accuracy of the pathologist.[5] With improvements in chemotherapy for lymphoma now resulting in significant longterm survival for many, the accurate diagnosis of this tumor is critical to the patient.

Immunohistochemistry can also aid in the subclassification of lymphomas.[6] Although limited immunologic studies can be performed on routinely fixed tissue, most lymphocyte surface markers can only be demonstrated on fresh, frozen tissue. Monoclonal antibodies to cell surface antigens are available which

Table 1. Partial List of Antigens Demonstrable by Immunohistochemistry.

Hormones	Neural antigens
insulin	S100
glucagon	neuron specific enolase
somatostatin	neurofilament
prolactin	glial filament acidic protein
ACTH	Oncofetal proteins
luteinizing hormone	carcinoembryonic antigen
growth hormone	alpha-fetoprotein
follicle stimulating hormone	Epithelial markers
thyroid stimulating hormone	cytokeratin
gastrin	epithelial membrane antigen
calcitonin	Soft tissue antigens
thyroglobulin	myoglobin
Estrogen receptor	actin
(preferably using	desmin
frozen or fresh tissue)	factor VIII
Infectious agents	Prostate specific antigen
cytomegalovirus	Prostatic acid phosphatase
herpes viruses	Leukocyte common antigen
hepatitis B	B & T lymphocyte antigens
	(preferably using
	frozen or fresh tissue)

Table 2. Lymphocyte Subsets.

WHO*	B-D** reagent	Ortho*** reagents	specificity†
CD1	Leu 6	OKT6	thymic cortical lymphocyte
CD2	Leu 5	OKT11	pan-T cell (sheep erythrocyte receptor)
CD3	Leu 4	OKT3	mature T cell
CD4	Leu 3	OKT4	helper/inducer T cell
CD5	Leu 1	OKT1	pan-T cell, some B cells
CD6			pan-T cell, some B cells
CD7	Leu 9		pan-T cell
CD8	Leu 2	OKT8	suppressor/cytotoxic T cell
CD20	Leu 16		pan-B cell

* CD ("cluster designation") nomenclature adopted by the World Health Organization Subcommittee on Immunology

** Leu designation of Becton-Dickinson Corporation, Mountain, View CA

*** OKT designation of Ortho Pharmaceutical Company, Raritan NJ

† Specificity with regard to lymphocytes only (for example, CD1 also labels Langerhans cells). Specificities listed are simplified in that there is some functional heterogeneity within CD4 and CD8 subsets.

Fig. 1A. Immunoperoxidase stain on infiltrating breast carcinoma demonstrates positivity for cytokeratin. Arrows highlight darkly staining positive tumor cells which contrast with lighter, negative stroma. (480×)

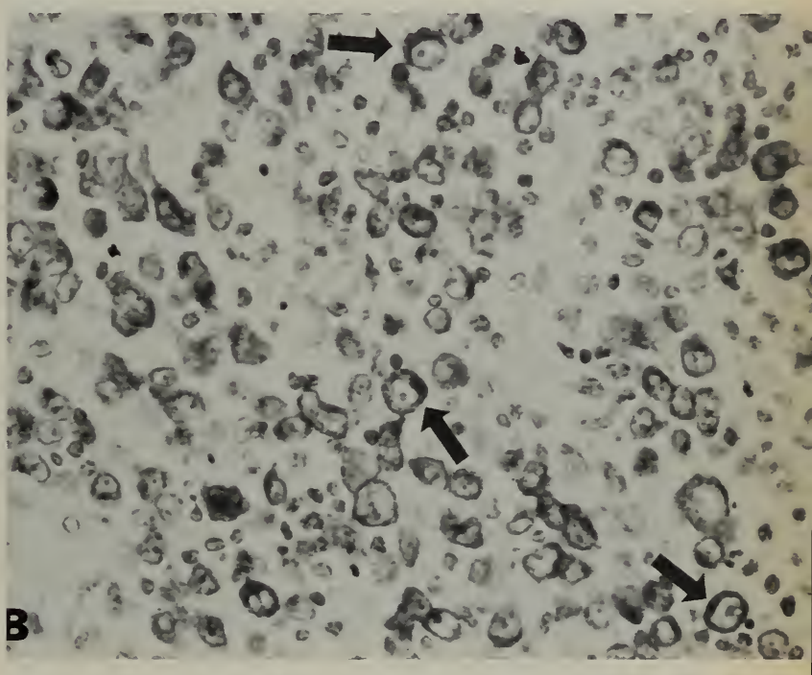

Fig. 1B. Immunoperoxidase stain on abdominal tumor, initially interpreted as malignant lymphoma, demonstrates cytokeratin reactivity in cytoplasm of tumor cells (arrows) consistent with diagnosis of poorly differentiated carcinoma. (480×) Immunoperoxidase stain on same tumor was negative for leukocyte common antigen.

distinguish B lymphocytes from T lymphocytes (Table 2). Various subsets of T cells can be identified (Fig. 2). Expression of immunoglobulin (Ig) by B cells can be detected. If only one Ig light chain (kappa or lambda) is present in a lesion, then the presence of a clonal population of cells is established. Reactive lesions contain both kappa- and lambda-producing B cells. Thus, if fresh tissue is available, a complete characterization of a lymphoma with regard to morphology and immunologic cell type can be obtained. Since reactive lesions may occasionally be difficult to distinguish from lymphoma, immunologic analysis may be an aid in diagnosis. Immunologic typing may also provide prognostic information which can be used in

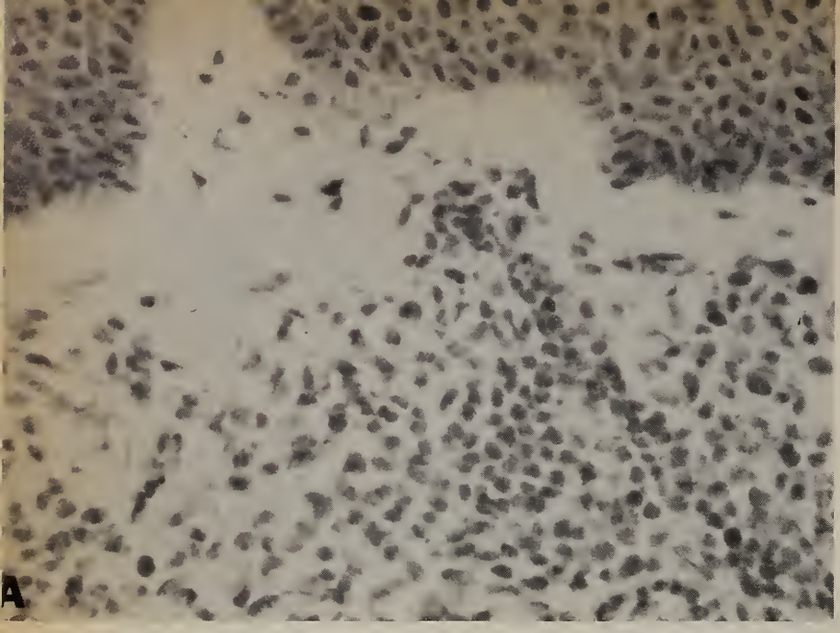

Fig. 2A. Photomicrograph of skin lesion (frozen section) illustrates lymphocytic infiltrate in dermis. (480×)

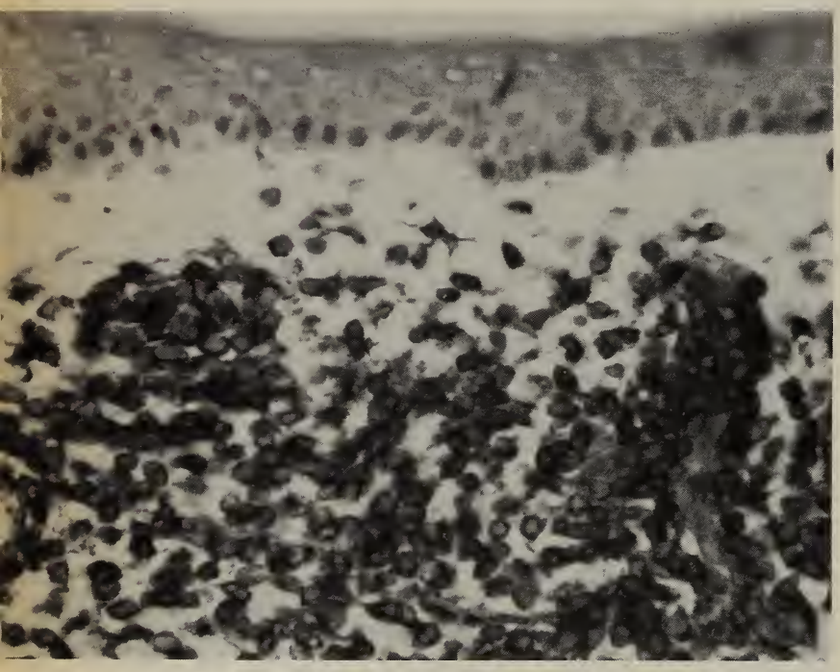

Fig. 2B. Immunoperoxidase stain demonstrates virtually all lymphocytes are T cells (CD3+). Dark rims around nuclei of lymphocytes correspond to positivity for surface antigen. These cells are also positive for CD4 ("helper/inducer" phenotype), which is consistent with diagnosis of cutaneous T cell lymphoma. (480×)

guiding treatment, and could be useful if experimental therapy with monoclonal antibodies directed against the tumor cells proves to be of value.

Another method of studying lymphomas is to analyze the DNA from the tumor cells. As lymphocytes mature, they undergo genetic rearrangements. For B cells, the rearrangements produce a gene which codes for a unique antibody. For T cells, the rearrangements produce a gene encoding for a unique antigen receptor. Using methodology developed by molecular biologists, the genes for immunoglobulins and T cell antigen receptors can be identified in a lymphoma.[7] If all the lymphocytes in a lesion contain the same genetic rearrangement, then they are a clonal population. This information can be useful diagnostically.

Finally, the total DNA content of a cell can be quantitated. A normal human cell contains 46 chromosomes ("euploid"). A malignant cell frequently has an abnormal number of chromosomes ("aneuploid"). Aneuploidy can be easily detected using a fluorescent dye, propidium iodide, that binds to DNA. The amount of fluorescence can then be measured using a flow cytometer (Fig. 3).[8]

A flow cytometer is an instrument which can quantitatively measure various cell parameters and fluorescent labels. A cell suspension is injected into the cytometer; the cells then pass in a single file at a rate of approximately 5,000 cells per second. As the cells pass through, they are exposed to an intense light of an exact wavelength produced by a laser. The amount of light scattered by the cell is quantitated by a sensor and provides a measure of certain characteristics such as cell size. In addition, when a fluorescent dye is used, the instrument can calculate the number of cells that are labeled and the quantity of the label present in each cell. Using this instrument, one can detect aneuploidy in a cell population. Other parameters such as cell size and rate of cell proliferation can also be measured.

A number of investigators have used this technique to analyze human malignancies. In bladder cancer, for example, malignant cells tend to be shed. Using flow cytometry to detect aneuploid cells in bladder washings in conjunction with morphologic examination by a cytopathologist, approximately 90% of bladder cancers can be identified. This improves the sensitivity of cytopathologic examination alone by 10-20%.[8,9]

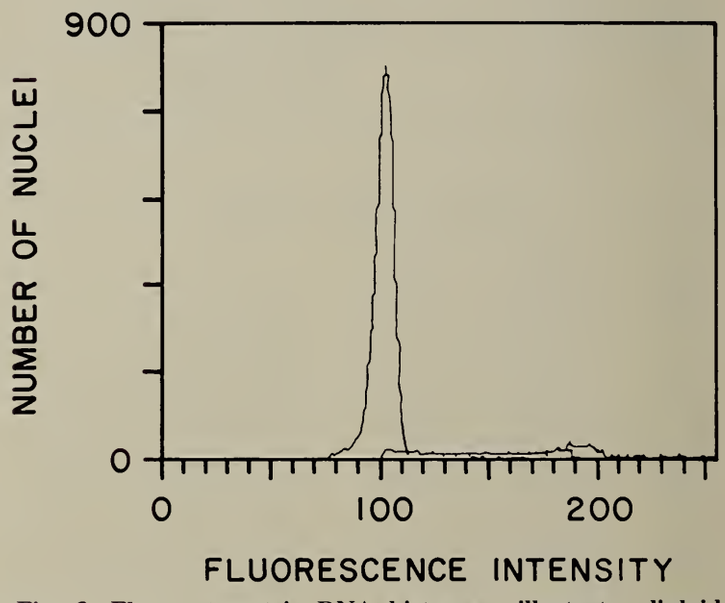

Fig. 3. Flow cytometric DNA histogram illustrates diploid breast carcinoma. Higher peak = cells in GO or GI phase (pre-DNA synthesis). Smaller peak to right = cells just prior to division (G2/M phase); they have twice diploid amount of DNA. Cells between peaks in process of synthesizing DNA (S phase). More rapidly proliferating tumors would have higher percentage of S phase. Aneuploid tumor would have second GO/GI peak distinct from diploid peak; the latter would represent inflammatory, endothelial or stromal cells and possibly a diploid clone of tumor cells.

Another malignancy recently studied by this method is cancer of the colon. Several investigators have reported that aneuploidy is a significant adverse prognostic factor.[8,10] In one study,[10] no tumor that was euploid metastasized, whereas the majority of those that were aneuploid behaved aggressively and caused the death of the patient.

In breast cancer, aneuploidy is a predictor of shorter disease-free survival.[8] Among patients without nodal involvement at the time of diagnosis, aneuploidy has been associated with a higher risk of early recurrence. This may be useful information in selecting which patients with localized disease should receive aggressive chemotherapy.

Other malignancies, such as lung cancer, renal cancer, gynecologic tumors, sarcomas, lymphoma and leukemia, have been studied for DNA content.[8] Although much work remains to be done, the technique offers promise for improving our ability to detect malignancy and identify those patients who need to be treated more intensively. Flow cytometry is especially applicable to fine needle aspiration specimens and may add to the information obtainable by cytopathologic examination.

The pathologist has many new tools which may aid in the evaluation of malignancy. Some, such as those described above, are beginning to be used clinically. Others, such as detection of activated oncogenes[11] and in-situ hybridization for detection of viral infection,[12] may have clinical applicability but are primarily investigational at present. Used with traditional morphologic examination, these newer techniques may provide information to improve the management and prognosis of the oncology patient.

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Venous Sonography for Pregnancy-Related Thrombosis: Case Report

Patricia L. Abbitt, MD, and
Siva Thiagarajah, MD,
Charlottesville, Virginia

Deep venous thrombosis (DVT) is a serious condition which may complicate pregnancy. Pulmonary embolism secondary to DVT has been reported as a leading cause of maternal death, and second only to abortion in one study.[1,2] Difficulties in diagnosis have made it difficult to determine the true incidence of pregnancy-related DVT. A reasonable estimate is that it occurs 5.5 times more frequently in the pregnant or postpartum patient than in the nonpregnant female.[1]

The clinical diagnosis of deep venous thrombosis based on history and physical examination is consistently unreliable. The risks of untreated DVT as well as the potential complications of anticoagulant therapy make accurate diagnosis imperative. Many different noninvasive techniques, including impedance plethysmography, phleborheography and radionuclide studies have been utilized in the evaluation of DVT, but venography is considered the "gold standard" in the diagnostic workup, despite its inherent problems. Disadvantages of venography include the invasive and often painful nature of the exam and the risks of the contrast medium, including allergic reactions, nephrotoxic effects and the irritant effect on the veins, which

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Submitted 9-2-88.

Fig. 1. Venous sonogram shows common femoral vein (arrows) filled with clot and noncompressible at site of thrombosis.

in turn may induce phlebitis. In pregnancy the radiation exposure to the fetus is an added risk.

Recent reports[3,7] have examined the efficacy of venous sonography for the detection of DVT in the thigh in the nonpregnant state. The veins from the level of the groin to the popliteal fossa can be evaluated by sonography for compressibility, the presence of an intraluminal clot, changes in diameter related to the Valsalva maneuver, as well as flow augmentation maneuvers. These studies suggest sensitivity rates of 89-96% and specificities of 97-100% for the detection of DVT in the thigh.

We present a pregnant patient in whom ileofemoral thrombosis was successfully diagnosed using venous sonography.

Case Report

A 33-year-old G2 P1 at 12 weeks gestation presented with a one-day history of acute right leg swelling and right calf pain radiating into the anterior thigh. She had experienced significant limitation in her recent normal activity level related to nausea and vomiting. She had no previous history of deep venous thrombosis. On examination, the right leg was noted to be warm, dusky and swollen, compared to the left. Deep venous thrombosis was the clinical diagnosis.

There was discussion regarding the best test to confirm the clinical diagnosis in this patient. There was reluctance to perform a venogram due to the risk of radiation exposure to the fetus. A venous sonogram (Fig. 1) showed the right common femoral vein to be engorged, filled with clot and noncompressible at the level of the groin. These features were diagnostic of deep venous thrombosis.

The patient was treated with intravenous heparin for several days until clinical symptoms abated. Thereafter therapy was continued with subcutaneous heparin. The patient was maintained on subcutaneous heparin through the remainder of the pregnancy.

Summary

Venous sonography offers a reliable, noninvasive way of diagnosing deep venous thrombosis in the lower extremity, a condition with a potentially fatal consequence. It is possible that sonography may underestimate the degree of involvement of the veins. However this is not usually of clinical concern since systemic heparin therapy will be given regardless of the extent of the clot.

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VIRGINIA MEDICAL

EDITORIAL

More on Smoking Bans

THE November 1988 issue of VIRGINIA MEDICAL carried the results of a survey on smoking in Virginia hospitals. In that survey there was only one Virginia hospital in which smoking was entirely forbidden, and that was a special facility, the 60-bed Charter Colonial Institute for Child and Adolescent Psychiatry in Newport News. Now from the University of Virginia comes the announcement ((*Helix*, Winter 1988-1989) that the new University of Virginia Hospital is entirely smoke-free. Smoking is forbidden throughout the interior of the hospital. The University of Virginia School of Medicine and the Hospital's administration are to be congratulated on their leadership.

Efforts to curb smoking in public places in Virginia continues. Gov. Gerald Baliles has signed into law a compromise anti-smoking bill, which will be in effect for just one year. During that time Del. Bernard Cohen (D-Alexandria), representing the anti-smoking faction, will work with the pro-smoking lobby to try to provide a plan that will satisfy the competing interests.

The noose tightens. E.L.K., JR., MD

Drug War

MY good friend Gilroy Lackluster and I had spent three miserable hours piecing together the face of a teen-aged car wreck victim, and we were worn out in body and mind. She and her dead boy friend were returning from a party of alcohol and drugs. It was depressing to see a young face so crushed. Before making our separate rounds, we decided to eat a late supper together since my family was out of town and Gilroy is both a confirmed bachelor and a bad cook.

To wind down before we ate, we met, as usual, at Queenie's Tavern to nurse an imported Hayem Shemon beer and to discuss the state of the world: How to solve the drug problem and how to prevent this type of tragedy.

Gilroy usually is apolitical, calling himself an independent thinker. As perverse as the public in general, Gilroy would rather criticize policy than help to form policy. He started to denigrate our current approach to the problem of illegal drugs.

"One 20-year-old dead and one 19-year-old mutilated plus one blind eye. My niece and nephew are that age, and it would kill my sister and me for that kind of tragedy to happen to our family. There has to be a better answer to the drug problem than our current policy. It is a failed policy. Why don't we admit it and change it? I am sick of seeing gunshot wounds from drug wars, horrible accidents from impaired judgment."

"Gilroy, what is wrong with you. Your thinking that the present approach has irretrievably failed is poppycock." I like to use old fashioned words now and then. It throws Gilroy off his stride. "I fully believe in our current war against drugs.

"If it takes the entire gross national product of this country to wage war against illegal drugs, we should do it. Once you get started on something this important, you must neither give up nor alter your course.

"If a patient is septic, you should pursue your original antibiotic treatment regardless of the bacteriological studies, regardless of the clinical course, It's

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just a matter of increasing the dose and trying harder, getting more nurses and doctors, getting more tests. If you do more and more and more of the same, you will succeed. Trying harder is part of the American tradition. I remember reading that classic tale about *The Little Engine That Could* to my children."

(Fortunately for my argument, Gilroy, had forgotten that only a month earlier I had been telling him about the South Carolina of my childhood, where the bootleggers and the hard-line, strictly religious, church-going people formed a curious alliance by voting alike to keep the counties dry. This alliance led to a better income for the former and to feelings of satisfaction and righteousness for the latter.)

"Why, I feel so strongly that I am in favor of pursuing the drug war even if it means declaring war on those countries whose economies depend upon drug production and distribution. We have nuclear bombs which we can use before they become obsolete, saving the cost of dismantling and disposing of them. Surely murder and massacre are justifiable in a cause as noble as this."

Gilroy was getting fidgety and looking at his watch. I knew that he was hungry and ready to eat and that I had this argument almost won. I ordered two more Hayem Shemon imported beers before he could stop me. It was a dirty tactic.

"If you are a wimp and don't want us to go to war or to nuke them, we have other alternatives. Anyone caught with any sort or any amount of illegal drug would be physically mutilated on the spot by amputating a digit for the first offense, an arm for the second offense, a leg for the third, etc.

"Now I realize that there are political problems in establishing this policy with all of those bleeding hearts out there, but those folks are easy to satisfy. All you have to do is to make exceptions to this strict, invariable policy for those who are Someone or are the relatives of Someone. That always satisfies the educated, influential, wealthy, bleeding-heart liberals.

"To satisfy the far right, hard-line, conservatives/reactionaries, first we would temporarily suspend all constitutional rights and guarantees. Next we would have Congress appoint a benevolent dictator to run the country and the drug war. The problem of deciding how to get the benevolent dictator to remain benevolent I leave to others.

"Gilroy, the only problem with our current drug policy is that we are not pursuing the drug war hard enough. Our policy has not failed. It's just a matter of warring long enough, hard enough, and dirty enough. We may even need a civil war to rid ourselves of the scum who use and sell drugs, who live in the slums, who are ignorant and uneducated, who speak poor English, who are not our friends or relatives or neighbors.

"Gilroy, I have met the enemy, and he is some folks not quite like us."

H. S. Campell, MD

GUEST SPEAKER

Fifty Years of Change

THE explosion of technology touched off during and following WWII has given medicine tools for diagnosis and treatment that are unparalleled in the history of medicine. Our abilities to help people, to ease pain and suffering were never better. Just think—there is no more smallpox in the world! An ancient and global disease of high mortality, one is now more likely to die from the complication of vaccination than from the disease itself.

But I think the most significant single advance in medicine in the last 50 years has been the development of antibiotics. Through the Thirties pneumococcal lobar pneumonia caused a large number of deaths and, with its sequelae, much chronic disability. Young people developed mastoid infections with great frequency, meningitis was greatly feared and carried a high mortality, treatment for gonorrhea was protracted, painful and largely unsatisfactory. In the late Thirties along came the sulfa drugs. The morbidity and mortality from lobar pneumonia dropped dramatically, mastoid infections fell to the point that physicians taking training in ear, nose and throat surgery did not have sufficient material with which to become proficient. Fifty years ago, it was not unusual to see persons with deep excavations behind the ear. Today these are rare.

In the early Forties penicillin was introduced. The causative agents of syphilis, gonorrhea, epidemic meningitis, streptococcal and staphylococcal organisms causing infections of the lungs, skin, urinary tract and other diseases too numerous to mention succumbed to its effects. But microorganisms were persistent. In less than a decade after penicillin's introduction, mutant strains of bacteria emerged against which penicillin was ineffective. As a result, chemists began synthesizing new antibiotics more effective than penicillin against bacterial mutants, resulting in further mutations and the need to develop further generations of antibiotics. The antibiotic treatment of infections disease has become a vast and complicated subspecialty of internal medicine. About the only microorganism still exquisitely sensitive to penicillin is *Treponema pallidum,* the causative agent of syphilis. And although syphilis is still with us, its reduction nationwide is remarkable. No longer are mental hospitals crowded with late-stage syphilitic patients as they were 50 years ago.

Tuberculosis has to a large measure disappeared through the aggressive use of antituberculosis drugs, skin testing, chest x-rays and, to a limited extent, vaccination. Primary intestinal TB hasn't been seen in 50 years owing to extensive pasteurization of milk. Most tuberculosis sanatoria have disappeared and surgeons no longer perform multilating operations to arrest the disease. This has come about through aggressive case-finding techniques, mass skin testing and treating with antituberculosis drugs those persons who develop positive skin tests even in the absence of overt disease. Today we show medical students tuberculous organs as museum specimens, because we no longer have a continuing supply of fresh tuberculous surgical or autopsy material. Thank God!

Even leprosy, a disease which once diagnosed meant spending the rest of one's life isolated from society, is now treated with drugs on an outpatient basis, and the Carville, Louisiana, leprosarium is a ghost of its former self.

Since the first big poliomyelitis epidemic in the late summer of 1916, epidemiologists have wondered where the next epidemic would strike. It could be anywhere. Its devastation was attested to by the number of persons with paralyzed, withered and deformed extremities, paralyzed muscles of respiration with a future in an iron lung. With the introduction of Salk vaccine in 1954 and, later, Sabin's oral vaccine, polio has virtually disappeared.

Vaccines have almost wiped out measles and German measles, whooping cough, diptheria and tetanus, the antisera for the latter two of which could produce reactions in some cases as bad as the disease itself. For travellers in endemic areas, there are vaccines against typhus and yellow fever; and for those whose employment poses a risk, there are vaccines against hepatitis and rabies.

Organ transplantation is a new art and science with tremendous potential. Corneal transplant was probably the first, but in the past 20 years, kidneys, more recently the heart, heart-lung combinations, the liver and, still in the experimental stage, implantation of adrenal gland cells into the brains of persons suffering from Parkinsonism.

Coronary artery bypass surgery has become in a decade one of the more common surgical procedures performed in America today. Not to belittle the surgeons who perform these delicate and complicated feats, they would be impossible without the support services of 1) immunology, which permitted transplantation without rejection by the recipient, and 2) modern blood banking, both of which were unheard of 50 years ago.

Additionally, replacement of joints, notably knee and hip, have taken on great importance to patients with crippling arthritis. Intraacular lens implants following cataract extraction have revolutionized ophthalmology.

The mood-altering drugs, tranquilizers and psychic-energizers, unheard of 50 years ago, are the most frequently prescribed medications in America today

and have been a panacea for many patients with psychoses, psychoneuroses and other emotional problems. Their use has resulted in the discharge of large numbers of patients from mental hospitals, public and private. However, this may be a mixed blessing because society must now cope with many of these unfortunate people living as street people. Thus a medical advance has created a sociological problem.

"The Pill", when properly used, is nearly 100% effective in pregnancy prevention. A predictable side effect of its use was/is the era of sexual permissiveness, with its far-reaching consequences, the AIDS epidemic being one of them. Like the bubonic plague of the 14th century, syphilis in the 16th, and poliomyelitis in the first half of the 20th, AIDS is spreading rapidly in the US and Europe and is now in most countries. There is not yet a medicine or vaccine to cure or prevent the disease. Until one or both is developed, the chief recourse is to educate the public about the various means of transmission and the most effective means of prevention available.

In the early Thirties, an obscure researcher at Cornell Medical School was studying changes in rat vaginal lining during the estrus cycle. By the Forties the human application of his study had evolved into the detection of malignant cells in the female genital tract and the name of George N. Papanicolaou immortalized the "Pap" smear. While female genital cancer is not yet preventable, its early detection through annual pap smears has resulted in early treatment, and death from this disease has been greatly reduced.

A vast literature pertains to the chemotherapy of cancer unheard of 50 years ago. New drugs are being developed almost daily, it seems, and have been tried with varying results on virtually all forms of cancers. These powerful cellular poisons are of some palliative value in malignancies of the lymphatic system, have been curative in many cases of Hodgkin's disease and in choriocarcinoma, a uterine cancer associated with the products of conception.

With such far-reaching advances, it is no wonder that American physicians have enjoyed a position of power, prestige and privilege unrivalled in any society elsewhere in the world, yet in little more than a decade doctors have suffered a fall from grace and are being humbled in a way that none of us would have predicted a generation ago. A large measure of the blame can be laid at the medical profession's doorstep. Too often patients and others see us as too concerned about our own comforts and too little concerned about the welfare of our fellow man. If we are to regain and hold our leadership position, we must act in ways to make the public believe we are working for them.

Willys M. Monroe, MD

Excerpted from a paper presented by Dr. Monroe on June 5, 1987, during the 50th reunion of his class at Wesleyan University, Middletown, Connecticut. Address correspondence to him at 5303 Ditchley Road, Richmond VA 23226.

OBITUARY

Memoir of Albert Spaar 1920-1989

By Charles H. Gleason, MD

The Albemarle County Medical Society sadly reports the death of one of its longtime, loyal members, Albert Peter Spaar, on February 22, 1989.

Dr. Spaar was born in New Orleans. After graduating from New Orleans public schools he attended the University of the South for two years and completed his undergraduate studies at Tulane University. He received his medical degree from Tulane University in 1945. Following graduation he served as a medical officer in the U.S. Navy. He returned to New Orleans and completed a residency in internal medicine. In 1950 he was called to serve as a naval medical officer in the Korean War. After the Korean War he completed a fellowship in cardiology at the Hanaman Institute in Philadelphia and practiced cardiology for ten years in Vernon, Texas.

In 1961 Dr. Spaar began a psychiatry residency at the University of Virginia and afterwards entered the private practice of psychiatry in Charlottesville. He was a member of the medical staff of the Martha Jefferson Hospital and was instrumental in developing inpatient services for psychiatric patients. Dr. Spaar was a founding member of the David C. Wilson Hospital, which provided a much needed facility for psychiatric patients in Central Virginia.

Dr. Spaar was a fellow in the American College of Cardiology, a member of the Academy of Psychosomatic Medicine, the American Psychiatric Association, the American Institute of Clinical Hypnosis, the Neuropsychiatric Society of Virginia, the Albemarle County Medical Society, The Medical Society of Virginia, and the American Medical Association.

Dr. Spaar was an active member of St. Paul's Memorial Episcopal Church in Charlottesville.

He is survived by his wife, Polly Amis Spaar; their children, Mrs. Katherine Amis Potapchuk, Mrs. Mary Scot Jonte, and Albert Peter Spaar; a sister, Mrs. Virginia Russell; and two grandchildren.

WHO'S WHO

Dr. G. Edward Calvert, Lynchburg, is the new president of Virginia's State Board of Medicine. He was elected at the board's meeting in March. A specialist in colon/rectal surgery, Dr. Calvert is a graduate of the Medical College of Virginia/VCU and was president of the Lynchburg Academy of Medicine in 1968. He was appointed to the board five years ago.

To serve with Dr. Calvert as vice president the board elected **Dr. F. Jay Pepper,** Alexandria psychiatrist, and as secretary treasurer, podiatrist Tony C. Bugera, also of Alexandria.

Dr. John F. Nowell is the new president of the Arlington County Medical Society, and **Dr. Ellsworth J. Stay** is the new secretary.

For the Chesapeake Medical Society, **Dr. Fred H. Seigel** will serve in the coming year as president and **Dr. Edward S. Hanna** as secretary.

The Fairfax County Medical Society's newly installed president is **Dr. Robert G. Matthews.** Serving with him as secretary is **Dr. Robert M. Allen.**

Dr. Bruce M. Birch is the newly elected president and **Dr. Kenneth J. Walker** the new secretary of the Southwestern Virginia Medical Society.

And further southwest, the Wise County Medical Society elected **Dr. G. S. Kanwal** as its new president and relected **Dr. Michael B. Ford** as secretary.

Ending 30 years of general practice on the Eastern Shore, **Dr. Edmund M. Henderson** closed his office in Nassawadox in February and prepared to get a lot of yardwork done at "Wellington," the old plantation house on Nassawadox Creek he and his wife Mary bought in 1953. There will also be more time for the boating and fishing he and Mary enjoy.

Dr. Henderson was born on the Eastern Shore and attended its public schools before leaving home to get his MD degree at the University of Virginia School of Medicine (Class of '42). He spent the next seven years in the Navy, then returned to Virginia to establish his private practice.

Dr. James E. Etheridge, Jr., chairman since 1978 of the Department of Neurology at Eastern Virginia Medical School, has been appointed interim dean of EVMS effective July 1. A graduate of the University of Virginia School of Medicine, Dr. Etheridge's specialty is pediatric neurology. He replaces **Dr. Richard G. Lester,** dean and vice president for academic affairs since 1984, who was appointed professor and chairman of the Norfolk school's new Department of Radiology.

When **Dr. Reinaldo Menendez III,** Emporia, retired from surgery late last year, he plunged directly into 1) helping with the startup of Stony Creek's Community Health Center; 2) renewing his interest in politics; and 3) writing a novel. "You can't go 100 miles per hour and then put on the brakes," he explained.

Born in Cuba, Dr. Menendez earned his MD at the University of Havana (Class of 1950), became a political activist, then emigrated to the US during the Castro revolution. In 1961, after internship and training in Norfolk, Dr. Menendez joined the new Greensville Memorial Hospital of Emporia as its first surgeon and stayed on there to help it grow from 40 to 127 beds and a galaxy of ancillary departments, including a nursing home.

At John Randolph Hospital, Hopewell, **Dr. Virgilio C. Supetran** is the new chief of the medical staff, and in Kilmarnock, **Dr. Robert E. Hoyt** is the new chief of staff at Rappahannock General Hospital.

Four years ago, when Va Med published a profile of Norfolk internist **Rudolf F. Schuster** (September 1984, pp 32–34), he was said to be "the fastest competitor in the 50-year bracket on the East Coast."

Early this year, at 62, Dr. Schuster was described on the front page of the *Richmond Times-Dispatch* as "one of the best age-group triathletes in the country" and the very model of a new breed of elderly

"Geriathlete" Schuster *Courtesy Richmond Times-Dispatch*

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competitors.

In his age category Rudi Schuster has won short- and long-distance running championships, annually wins national biking championships, and has placed first in his age group in the New Zealand Ironman Triathlon, where the extended international format includes a complete marathon. The biking he began during his formative years in Germany, where he earned his MD at the medical school of Ludwig Maximilian University in Munich, and swimming he learned when young, too. He began running in Norfolk in 1970.

Now his routine weekly physical conditioning includes 25–30 mi of running, 3 mi of swimming, and 150 mi of biking. When he's training for a competition that regimen is beefed up.

Said the executive director of the Norfolk YMCA to newspaper reporter Betty Booker as they watched Rudi Schuster run by, "How many 25-year-olds have you seen with legs like that? He's the personification of fitness. He's built to live."

Theme of the newspaper's big, two-part article was that not only are there more people in the last decades of life today, but some of them have pursued training and healthy ways of living so that they can compete, often for the first time in their lives, in serious athletic trials.

"It's a huge trend, and it's just begun," observed Dr. Sheldon M. Retchin, chairman of the Medical College of Virginia's Division of Geriatric Medicine. He has coined the word "geriathlete" to denote athletes 60 and over who perform well in regional and world-class competition.

Correction

When **Dr. Walter R. Wallingford** opened his Norfolk office recently, he retained his Hampton, Newport News (Denbigh), and Williamsburg locations. A Who's Who entry in the April issue indicated otherwise.

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Directory of Virginia Physicians 1989

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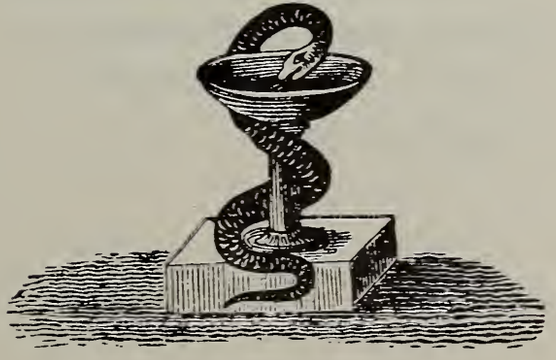

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Fairfax VA 22031
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Virginia Beach VA 23454
Orthopedic Surgery

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McLean VA 22101

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Psychiatry

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Ophthalmology

Abedi, Shahla Asl, MD
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Ophthalmology

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1502 Featherstone Rd
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Ophthalmology

Abenes, Gil A, MD
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P O Box CVPI
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Pediatrics

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Abhyankar, Ramola Sharad, MD
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Herndon VA 22071
Emergency Medicine

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Patient First
Richmond VA 23219

Abraham, Samathanam Nithiyanandan, MD
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Portsmouth VA 23703
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Alexandria VA 22302
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Richmond VA 23229
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Grundy VA 24614
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Wise VA 24293

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Norfolk VA 23507
(804) 446-8940
Gynecology

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2104 Hartford Rd
Hampton VA 23666
General Practice

Acquavella, Anthony Peter, MD
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Mechanicsville VA 23111
Pediatrics

Acra, Wadi De Jesus, MD
De Paul Med Bldg #305
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(804) 486-1211
General Surgery

Adamek, Walter John Jr, DO
719 Galahad Dr
Newport News VA 23602

Adamonis, Alan James, MD
107 Tarpon Dr
Yorktown VA 23692
Anesthesiology

Adams, Cheryl Teres, MD
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Roanoke VA 24016
Pediatrics

Adams, Douglas H, MD
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Roanoke VA 24014
Family Practice

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2001 N Adams St
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2630 Robert Walker Pl
Arlington VA 22207
General Practice

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217 Southpoint Dr
Williamsburg VA 23185
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Richmond VA 23227
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128-A Stribling Ave
Charlottesville VA 22903
General Surgery

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Martinsville VA 24112
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Family Practice

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1224 Westover Ave
Norfolk VA 23507
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Norfolk VA 23510
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Weber City VA 24251
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Obstetrics/Gynecology

Adler, Adrienne Cicile, MD
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Obstetrics/Gynecology

Adler, Robert Alan, MD
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Bluefield VA 24605
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Ahmadi, Satar Abdul, MD
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3650 Joseph Siewick Dr
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Akhtar, Saleha Siddiqui, MD
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Specialty Listing begins on page 259.

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Burke VA 22015
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Internal Medicine

Alderfer, Richard D, MD
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Radford VA 24141
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General Practice

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Charlottesville VA 22903
Psychiatry

Aldrich, Marc Nathan, MD
15337 Inlet Pl
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General Practice

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Fairfax VA 22033
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Alerte, Marie Claude Aurubin, MD
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Alexander, Michael B, MD
611 S Carlin Springs Rd #203
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Alexander, Robert Clifton, MD
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Psychiatry

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P O Box 3462
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Alfonso, Raymundo Palad, MD
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602 Med Tower
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2705 Meeting Gate Ct
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Radiology

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Chesterfield VA 23832
Anesthesiology

Alisuag, Andres Jr, MD
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(703) 369-7744
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Orthopedic Surgery

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Arlington VA 22205
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Allen, Benjamin F, MD
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Culpeper VA 22701
(703) 825-5362
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Richmond VA 23229
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Clifton Forge VA 24422
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Radiology

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Catawba Hosp
Catawba VA 24070
Internal Medicine

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Sterling VA 22170
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Richmond VA 23225

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Hampton VA 23666

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(703) 345-1561
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Charlottesville VA 22901
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Radiology

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Internal Medicine

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Fairfax VA 22033
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General Surgery

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Neurology

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618 Butler Ave
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Vienna VA 22180
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Ophthalmology

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Roanoke VA 24016
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McLean VA 22102
Pediatrics

Altman, Robert Michael, MD
428 Wolfe St
Alexandria VA 22314

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2315 Essex Rd
Richmond VA 23228-6032
General Surgery

Alvarado, Maritza, MD
357 Pender Ct
Norfolk VA 23517
Pediatrics

Alvarado-Echeverria, Marcio A, MD
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Alexandria VA 22311
Pediatrics

Alvir, Rene B, MD
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Arlington VA 22204
(703) 491-1800
Urological Surgery

Amalfitano, Diane Marie, DO
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Arlington VA 22207

Amarasinghe, D C, MD
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Virginia Beach VA 23455
(804) 499-3900
General Surgery

Amari, Salvatore N, MD
65 Gibson St #207
Leesburg VA 22075
Internal Medicine

Amberman, George Herbert III, MD
921 Eastern Shore Rd
Virginia Beach VA 23454
General Practice

Ambury, James F, MD
3416 S 9th St
Arlington VA 22204
Internal Medicine

Amedeo, Ralph M, MD
1715 N George Mason Dr #306
Arlington VA 22205
(703) 276-0630
Internal Medicine

Ameen, Richard J, MD
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Fredericksburg VA 22401
(703) 786-3627
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Roanoke VA 24019
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Family Practice

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Charlottesville VA 22908

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Pediatrics

Amin, Jyoti S, MD
Alexandria Hosp
Alexandria VA 22304
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Amin, Sanjay M, MD
1401 Tidewater Dr #9
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Amin, Surendra P, MD
5001 Seminary Rd #120
Alexandria VA 22311
Internal Medicine

Amini, Massoud, MD
1101 S Ridge Rd #1001
Arlington VA 22202
Otolaryngology

Amiri, Cyrus S, MD
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Norfolk VA 23507
(804) 623-0526
Otolaryngology

Ammann, Albert M, MD
1403 Riversedge Rd
Newport News VA 23606
Radiology

Ammann, Kathleen Mraz, MD
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Clinical Pathology

Ammerman, Richard Gene, MD
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Reston VA 22091
Psychiatry/Neurology

Ammermann, E Gifford, MD
V A Hosp
Salem VA 24153
Anatomic/Clinical Pathology

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9705 Bunker Ct
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General Surgery

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2132-1B Criston Dr
Newport News VA 23602
Family Practice

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Internal Medicine

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Obstetrics/Gynecology

Amorosi, Leo David, MD
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McLean VA 22101
Obstetrics/Gynecology

Amory, Harold I, MD
363 Brout Dr
Hampton VA 23666
Radiology

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Specialty Listing begins on page 259.

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Specialty Listing begins on page 259.

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7354 Eldorado St
McLean VA 22102
General Surgery

Baganz, Herbert M Jr, MD
1131 Crest Ln
McLean VA 22101
Internal Medicine

Bagby, Bathurst B Jr, MD
Rte 1 Box 1244
Kilmarnock VA 22482
Physical Medicine/Rehabilitation

Baggerly, John Thomas Jr, MD
P O Box 2129
Danville VA 24541
(804) 799-2100
Radiology

Baggs, W James, MD
328 Main St
Newport News VA 23601
Obstetrics/Gynecology

Bagley, Clifford E, MD
12605 Hazelwood Dr
Nokesville VA 22123
Urological Surgery

Bagley, John J, MD
7605 Forest Ave #212
Richmond VA 23229
(804) 285-8300
Obstetrics/Gynecology

Bagnick, Joseph Francis, MD
26 Cedarwood Way
Newport News VA 23602
Internal Medicine

Bailey, Andrew Allison Jr, MD
400 Locust Ave #2B
Charlottesville VA 22901
General Surgery

Bailey, Charles C, MD
301 Carrsbrook Dr
Charlottesville VA 22901
Internal Medicine

Bailey, Dewey James, MD
2037 Crystal Spring Ave S W #1
Roanoke VA 24014
(703) 345-0907
Internal Medicine

Bailey, Dewey James III, MD
4713 W Grace St
Richmond VA 23230
Internal Medicine

Bailey, Dwight L, MD
Rte 3 Box 71
Lebanon VA 24266
Family Practice

Bailey, Gary Alan, MD
1031 S Main St #6
Harrisonburg VA 22801
(703) 433-0492
Urological Surgery

Bailey, George W, MD
621 South St Asaph St
Alexandria VA 22314
Pediatrics

Bailey, James Paul, MD
4 Maynard St
Hampton VA 23661
(804) 723-4221
Psychiatry

Bailey, Lawrence Delmore Jr, MD
1408 Forest Ridge Rd
Charlottesville VA 22903
Internal Medicine

Bailey, Paul Allen, MD
440 Glasgow St #B
Portsmouth VA 23704
Family Practice

Bailey, Robert Liston Jr, MD
Rte 2 Box 207B
Weems VA 22576
(804) 435-6703
Internal Medicine

Bailey, Robert Rives, MD
307 Cook Rd
Yorktown VA 23690
(804) 898-7261
General Practice

Bailey, Steven Leroy, MD
1708 Dylan Dr
Virginia Beach VA 23464
Anesthesiology

Bailey, Thomas Daniel, MD
7327 Timberlake Rd
Lynchburg VA 24502
Emergency Medicine

Bailey, William T, MD
8320 Trabue Rd
Richmond VA 23235
Nuclear Medicine

Specialty Listing begins on page 259.

Bailie, Allston Gibbes, MD
204 N Hamilton St
Richmond VA 23221
(804) 359-3155
Pulmonary Diseases

Bain, Francis Nott, MD
Box 669
Goochland VA 23063
(804) 556-6101
Family Practice

Bain, James Britton, MD
205 Princess Anne Rd
Waynesboro VA 22980
(703) 942-5944
Ophthalmology

Bain, Thomas Herbert, MD
Box 459
Crozet VA 22932
(804) 823-4567
Internal Medicine

Baines, Bryan Nicholas, MD
124-2C Jefferson Point Ln
Newport News VA 23602

Baird, Charles Lewis Jr, MD
205 N Hamilton St
Richmond VA 23221
(804) 359-9265
Cardiovascular Diseases

Bajit, Marieta Agawin, MD
809 Brandon Ave #210
Norfolk VA 23517
(804) 622-5091
Anesthesiology

Bajoghli, Mehdi, MD
2200 Opitz Blvd #230
Woodbridge VA 22191

Bajwa, Gurnam S, MD
1129 N Main St
South Boston VA 24592
General Surgery

Bajwa, Manjit Rajinder, MD
1007 Heather Hill Ct
McLean VA 22101
Anesthesiology

Baker, Bruce Edward, MD
150 Old Greenwich Dr #J
Fredericksburg VA 22401
(703) 898-5533
Psychiatry

Baker, Frances W, MD
7446 N Shore Rd
Norfolk VA 23505
Pediatrics

Baker, James Edward, MD
401-42 Merrimac Trail
Williamsburg VA 23185
Psychiatry/Neurology

Baker, James Porter, MD
EVMS Box 1980
Norfolk VA 23501
(804) 446-8912
Pulmonary Diseases

Baker, James Pray, MD
P O Drawer 420
Warrenton VA 22186
General Surgery

Baker, James Russell Jr, MD
1306 Michigan Ave
Alexandria VA 22314
Internal Medicine

Baker, Jay Milton, MD
1509 Narbonne Ct
Virginia Beach VA 23456
Obstetrics/Gynecology

Baker, John Harrison, MD
Governor Berkeley Proff Ctr
Williamsburg VA 23185
Obstetrics/Gynecology

Baker, John William Jr, MD
844 Kempsville Rd #105
Norfolk VA 23502
(804) 461-2515
General Surgery

Baker, Joseph Wilmler, MD
Rte 1 Box 354 Hedge Hall Farm
Covesville VA 22931
General Surgery

Baker, Lenox Dial Jr, MD
400 W Brambleton Ave #200
Norfolk VA 23510
(804) 622-2677
Thoracic Surgery

Baker, Richard Holden, MD
Student Health Services
Blacksburg VA 24061
Obstetrics/Gynecology

Baker, Robert E, MD
3640 High St #3C
Portsmouth VA 23707
(804) 399-2639
Ophthalmology

Baker, Stephen Robert, MD
10800 Old Georgetown Pike
Great Falls VA 22066
Psychiatry/Neurology

Baker, Stuart B, MD
850 Kempsville Rd
Norfolk VA 23502
Internal Medicine

Baker, Wallace Edgar, MD
General Delivery
White Marsh VA 23183
(703) 451-3330
General Practice

Baker, William B, MD
1040 Main St
Danville VA 24541
(804) 792-1433
Internal Medicine

Baker, William Frank, MD
1330 Oak Ln #205
Lynchburg VA 24503
(804) 384-5437
Obstetrics/Gynecology

Baker, William Powell, MD
1008 Westover Ave #302-B
Norfolk VA 23507

Bakhru, Aruna Govind, MD
11484 Washington Plaza W
Reston VA 22090

Bakht, Shoaib, MD
3315 County St
Portsmouth VA 23707
Internal Medicine

Bakht, Sufia Begum, MD
3315 County St
Portsmouth VA 23707
Pediatrics

Bala, Meena E, MD
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Chester VA 23831
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General Practice

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Virginia Beach VA 23455

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Internal Medicine

Balasubramaniam,
Meenakshsundaram, MD
Big Stone Gap Clinic
Big Stone Gap VA 24219
Pediatrics

Baldemor, Anita B, MD
258 W Main St
Danville VA 24541
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Child Psychiatry

Baldinger, John Charles, MD
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Fairfax VA 22031
Ophthalmology

Baldo, Edna Reyes, MD
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Burke VA 22015
Radiology

Baldwin, Ernest Frank III, MD
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Lexington VA 24450
Internal Medicine

Baldwin, Monroe Glass Jr, MD
2542 Langhorne Rd
Lynchburg VA 24501
(804) 846-5297
Urological Surgery

Baldwin, Nevan George, MD
1200 E Broad St
Richmond VA 23298

Balestrieri, Francis Joseph, MD
3459 N Venice St
Arlington VA 22207
Anesthesiology

Balingit-Gonzales, Purita E, MD
6212 Stoneham Ln
McLean VA 22101
Anesthesiology

Balint, Virgil Aurel, MD
203 Yoakum Pkwy
Alexandria VA 22304

Ball, Achana Vimuktalaba, MD
3221 Martha Custis Dr
Alexandria VA 22302
Pediatrics

Ball, John Edward, MD
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Alexandria VA 22304
(703) 751-4421
Anesthesiology

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Ball, Michael Francis Jr, MD
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Annandale VA 22003
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Ball, Michael J, MD
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Internal Medicine

Ball, William Flinn, MD
2429 S Jefferson St
Roanoke VA 24014
Family Practice

Ballard, Peter Francis, MD
176 Valley St N W
Abingdon VA 24210
Otolaryngology

Ballenger, Fred Jackson, MD
1117 S Jefferson St
Roanoke VA 24016
(703) 344-1400
Internal Medicine

Ballitch, Harold Andrew II, MD
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Richmond VA 23225

Ballo, Joseph M, MD
Wild Flowers
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Forensic Pathology

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Psychiatry

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Internal Medicine

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Internal Medicine

Balsamo, Pat A, MD
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Pediatrics

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Nuclear Medicine

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Center Psychiatrists
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General Practice

Balzarett, Joseph Raymond, MD
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Vienna VA 22180
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Child Psychiatry

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Wise VA 24293
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General Surgery

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South Boston VA 24592
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Internal Medicine

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Newport News VA 23606
Pediatrics

Bane, Earle M, MD
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General Practice

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Obstetrics/Gynecology

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Internal Medicine

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Banks, James William III, MD
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Banks, Marshall D, MD
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Richmond VA 23220
Urological Surgery

Banner, Robert L, MD
7601 Forest Ave #338
Richmond VA 23229
General Surgery

Banning, Bruce Cramer Jr, MD
Lewis Gale Hosp Radiology
Salem VA 24153

Bannister, Warren Dale, MD
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Anatomic/Clinical Pathology

Banzon, Amando L Jr, MD
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Springfield VA 22152
Family Practice

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Psychiatry

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General Surgery

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Charlottesville VA 22901
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Barbour, Galen Lane, MD
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Newport News VA 23601
Internal Medicine

Barchas, Rebecca E, MD
Windwood Centre
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Barclay, Charles O Jr, MD
462 Washington St
Portsmouth VA 23704
General Practice

Bardakjian, Vatche Barkev, MD
1508 Westfield Ct
Charlottesville VA 22901
General Surgery

Bardin, Robert Malcolm, MD
1300 Bernard St
South Boston VA 24592
General Practice

Barefoot, Sherwood Washington, MD
533 Mossycup Dr
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Cardiovascular Surgery

Barham, Edward Adolphus, MD
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Portsmouth VA 23704
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Family Practice

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Family Practice

Barker, William J, MD
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Emergency Medicine

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Burke VA 22015
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Ophthalmology

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Richmond VA 23225

Barnard, John W, MD
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Portsmouth VA 23704
(804) 397-7071
Psychiatry

Barnard, John William, MD
1802 Braeburn Dr
Salem VA 24153
Radiology

Barnes, David Wright, MD
7204 Timberlake Rd
Lynchburg VA 24502
General Practice

Barnes, Everett D, MD
1707 Osage St #400
Alexandria VA 22302
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Obstetrics/Gynecology

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11 Hidden Valley Ln
Radford VA 24141
Psychiatry/Neurology

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Family Practice

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11741 Kingstowne Rd #515
Newport News VA 23606

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1348 Chetworth
Alexandria VA 22314
Obstetrics/Gynecology

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Charlottesville VA 22908
(804) 296-9411
Family Practice

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505 Cedarbrooke Ln
Richmond VA 23229

Barnett, Jewell Milton, MD
606 Denbigh Blvd #701
Newport News VA 23602
Obstetrics/Gynecology

Barnett, Mark Gordon, MD
505 Cedarbrook Ln
Richmond VA 23229

Barney, William H, MD
1935 Thomson Dr
Lynchburg VA 24501
(804) 528-3113
Internal Medicine

Barnhart, Glenn R, MD
400 W Brambleton Ave #200
Norfolk VA 23510
(804) 622-2677
Cardiovascular Surgery

Barnhart, Ruth, MD
3533 Penarth Rd S W
Roanoke VA 24014
(703) 344-3686
Pediatrics

Baron, George P, MD
Lewis-Gale Hosp
Salem VA 24153
Anesthesiology

Baron, Paul Lawrence, MD
9821 Groundhog Dr
Richmond VA 23235
General Surgery

Barone, Gary Wickens, MD
708 Cargil Ln
Charlottesville VA 22901
General Practice

Barongan, Amor A, MD
P O Box 1080
Norton VA 24273
Internal Medicine

Barongan, Pablo P, MD
P O Box 1080
Norton VA 24273
Internal Medicine

Barot, Amrutlal Jethalal, MD
1109 Chatmoss Dr
Virginia Beach VA 23464
Neurology

Barot, Lydia M, MD
2616 Sherwood Hall Ln
Alexandria VA 22306
Pediatrics

Barquist, Walter Eric, MD
1850 Cameron Glen Dr
Reston VA 22091
Psychiatry

Barr, Arnold B, MD
839 Poplar Hall Dr
Norfolk VA 23502
Endocrinology

Barr, Lisa Binder, MD
419 Hariton Ct
Norfolk VA 23505
Family Practice

Barr, Mark Cameron, MD
9325 Midlothian Tnpk
Richmond VA 23235
(804) 271-2702
Family Practice

Barr, Norman Lee Jr, MD
1515 Chain Bridge Rd
McLean VA 22101
Otolaryngology

Barr, Robert W, MD
107 N Virginia Ave
Falls Church VA 22046
(703) 532-4446
Pediatrics

Barr, William Clayton, MD
5507 Toddsbury Rd
Richmond VA 23226
(804) 282-8746
Radiology

Barranco, S D, MD
3708 S Main St #A
Blacksburg VA 24060
(703) 951-4511
Orthopedic Surgery

Barreca, Joseph Peter Jr, MD
3500 South St
Portsmouth VA 23707
(804) 397-4689

Barrera, Francisco R, MD
P O Box M
Woodbridge VA 22194
(703) 494-3772
Internal Medicine

Specialty Listing begins on page 259.

Barrett, Christine E, MD
312 N Main St
Rocky Mount VA 24151
General Surgery

Barrett, Debra Ann, MD
328 Southern Ct
Highland Springs VA 23075
Obstetrics/Gynecology

Barrett, Francis E, MD
2815 Wighton Dr
Richmond VA 23235
(804) 231-9011
Pulmonary Diseases

Barrett, Michael Arthur, MD
3380 N Dickerson St
Arlington VA 22207
Internal Medicine

Barrick, E Frederick, MD
1499 Chain Bridge Rd #100
McLean VA 22101
(703) 442-7316
Orthopedic Surgery

Barringer, Michel Laron, MD
Box 7348
Richmond VA 23221
(804) 358-2361
Pediatrics

Barritt, A Sidney III, MD
V A Hosp
Salem VA 24153
Internal Medicine

Barrow, Frederick P II, MD
3100 Shore Dr #529
Virginia Beach VA 23451
Radiology

Barrow, Guy J, MD
185 Crestview Dr
Abingdon VA 24210
Internal Medicine

Barry, Fredrick, MD
101 First St
Radford VA 24141
Internal Medicine

Barsanti, Ardwin H, MD
5113 Philip Rd
Annandale VA 22003
(703) 256-7200
Pediatrics

Barsanti, Christopher Michael, MD
Rte 2 Box 76
Earlysville VA 22936
General Surgery

Barsanti, Ronald G, MD
8620 Redwood Dr
Vienna VA 22180
(703) 938-2244
Pediatrics

Barsanti, Thomas G, MD
7680 Willow Point Dr
Falls Church VA 22042
(703) 698-3195
Emergency Medicine

Barta, Joseph A Jr, MD
P O Box 1172
Radford VA 24141
(703) 639-2770
Ophthalmology

Bartel, Alan Gilbert, MD
400 W Brambleton Ave #201
Norfolk VA 23510
(804) 623-3800
Cardiovascular Diseases

Barth, Robert Lewis, MD
1120 Laurelwood Dr
McLean VA 22102
(703) 698-3138
Anesthesiology

Bartis, Lois Cohen, MD
6888 Elm St #2D
McLean VA 22101
Internal Medicine

Bartlett, Donald E Jr, MD
3612 Winding Way Rd
Roanoke VA 24015
General Surgery

Bartley, Cavitt K, MD
5004 Shadyside Dr S W
Roanoke VA 24018
General Practice

Bartley, Homer, MD
17 Highland Ave S W
Roanoke VA 24016
(703) 345-0779
General Practice

Bartman, Barbara Ann, MD
2000 N Adams St #634
Arlington VA 22201
Internal Medicine

Bartok, Stephen Paul, MD
P O Box 400
Gloucester Point VA 23062
Radiology

Bartol, Dennie Thomasson, MD
113 William Barksdale
Williamsburg VA 23185
Radiology

Barton, Bette Lee, MD
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Arlington VA 22207

Barton, Charles Robert Jr, MD
Box 151
Scottsville VA 24590
General Practice

Barton, James Edwin, MD
706 Jamestown Rd
Williamsburg VA 23185
Family Practice

Barton, Sam, MD
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Midlothian VA 23113
(804) 232-5770
Family Practice

Barton, Walter S, MD
P O Box 718
Wytheville VA 24382
Family Practice

Bartone, Mary Williamson, MD
8301 Arlington Blvd
Fairfax VA 22030
(703) 560-4211
Family Practice

Bartram, Scott F, MD
200 Little Falls St #301
Falls Church VA 22046
General Practice

Bas, Mauricio D Jr, MD
1970 Opitz Blvd
Woodbridge VA 22191
(703) 494-8174
Thoracic Surgery

Basala, Marylu, MD
701 Stockley Gardens #2
Norfolk VA 23507

Basham, Mark Cash, MD
4064 Windsor Gate Pl
Virginia Beach VA 23452
Internal Medicine

Bashir, Abbas, MD
108 N Virginia Ave
Falls Church VA 22046
(703) 534-3320
Gastroenterology

Bashore, Randall Thomas, MD
P O Box 220
New Canton VA 23123
Internal Medicine

Basile, Michael Joseph, MD
1310 Third St S W
Roanoke VA 24016
(703) 345-4946
Internal Medicine

Basile, Vincent T, MD
4330 Old Cave Spring Rd S W
Roanoke VA 24018
(703) 989-6167
Anesthesiology

Baskerville, A L, MD
4630-D S Laburnum Ave
Richmond VA 23231
(804) 222-5427
Cardiovascular Diseases

Baskett, Sarah Josephine, MD
6460-C Hanover Crossing Dr
Mechanicsville VA 23111
Psychiatry

Bason, William M, MD
800 W Olney Rd
Norfolk VA 23507
Pediatrics

Bass, Rita Almira, MD
7036 Arbor Ln
McLean VA 22101

Bass, Robert Redwood, MD
1475 Spring Meadow Ln
Suffolk VA 23432
Family Practice

Bass, Stuart Kenneth, MD
7727 Stuart Hall Rd
Richmond VA 23229
Emergency Medicine

Bass, William P, MD
165 Woodland Dr
Bristol VA 24201
Anesthesiology

Bass, William Thomas, MD
Childrens Hosp Kings Daughter
Norfolk VA 23507
Pediatrics

Bassham, Harold Lee, MD
P O Box 866
Abingdon VA 24210
(703) 628-9331
Radiology

Bassig, Ricardo A, MD
923 Prosperity Ct
Fredericksburg VA 22401
General Practice

Basso, Alessandro G, MD
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Winchester VA 22601
(703) 662-0377
Urological Surgery

Basta, Barbara Josephine, MD
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Arlington VA 22206
Psychiatry

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Internal Medicine

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Hampton VA 23661

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Obstetrics/Gynecology

Bates, Hampton Robert Jr, MD
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Richmond VA 23225
(804) 320-3911
Nuclear Medicine

Bates, Harry Clark III, MD
Dejarnette Center
Staunton VA 24401
Psychiatry/Neurology

Bates, Harry Clark Jr, MD
P O Box 368
Rixeyville VA 22737
(703) 937-5552
Occupational Medicine

Bates, Jesse J, MD
521 Webster St
South Boston VA 24592
Family Practice

Bates, Robley D III, MD
1455 Johnston Willis Dr
Richmond VA 23235
(804) 358-9165
Urological Surgery

Battafarano, Nicholas Joseph, MD
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Batte, William Henry, MD
8107 Pace Rd
Norfolk VA 23518
(804) 583-8438
Psychiatry

Battista, Joseph Victor Jr, MD
5855 Bremo Rd #205
Richmond VA 23226
(804) 288-4084
Obstetrics/Gynecology

Battle, Donald C, MD
1021 Potomac Ln
Alexandria VA 22308
Family Practice

Bauer, Paul Richard, MD
4037-C Taylor Rd
Chesapeake VA 23321
Obstetrics/Gynecology

Bauernfeind, Robert Allen, MD
10704 Green Mount Rd
Richmond VA 23233
Internal Medicine

Baugh, Emerson D Jr, MD
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Kenbridge VA 23944
(804) 676-8021
Family Practice

Baugh, Thomas A, MD
132 South Ave
Petersburg VA 23803
General Practice

Baughman, Earle W Jr, MD
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Alexandria VA 22302
Psychiatry/Neurology

Bauknight, Gerald Conrad Jr, MD
612 Elgin Ter
Richmond VA 23225
Internal Medicine

Baum, Joseph James, MD
Tri-Area Health Clinic
Laurel Fork VA 24352
Family Practice

Bautista, Divinia Maliwat, MD
204 Woodville Dr
Forest VA 24551
Pediatrics

Bawa, Balraj, MD
2705 Farmington Pl
Lynchburg VA 24503
Pediatrics

Baxter, Robert Francis, MD
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Grundy VA 24614
(703) 935-6127
Family Practice

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Pediatrics

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Baylor, Richard Norton, MD
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Kilmarnock VA 22482
(804) 539-0251
Internal Medicine

Bayne, David P, MD
2204 Exec Dr #E
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(804) 838-8836
Urological Surgery

Bazaco, George Constantine, MD
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Oakton VA 22124
(703) 385-8722
Pulmonary Diseases

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Arlington VA 22204
(703) 379-7331
Neurology

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(804) 572-4538
General Surgery

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Psychiatry

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Danville VA 24541
(804) 793-1231
Pediatrics

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Vienna VA 22180
(703) 938-4422
Urological Surgery

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Fredericksburg VA 22401
(703) 899-3434
Urological Surgery

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Nephrology

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Richmond VA 23298
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Medical Oncology

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Beargie, Richard J, MD
10721 Main St #104
Fairfax VA 22030
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Beasley, Walter Ewing III, MD
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General Surgery

Beatie, William Edward, MD
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Alexandria VA 22310
Orthopedic Surgery

Beatiey, Robert Eugene, MD
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General Practice

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Specialty Listing begins on page 259.

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Specialty Listing begins on page 259.

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Specialty Listing begins on page 259.

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The Gathering
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Brown, Kimberley Louise, MD
Louise Obici Mem Hosp Patholo
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Specialty Listing begins on page 259.

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Urological Surgery

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Internal Medicine

Budding, Jacobus, MD
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Newport News VA 23606
Abdominal Surgery

Buddington, R S, MD
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Abingdon VA 24210
Anatomic/Clinical Pathology

Buenaventura, Frank A, MD
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Anesthesiology

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Pulmonary Diseases

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Pulmonary Diseases

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Obstetrics/Gynecology

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Williamsburg VA 23185

Bulger, Elizabeth Ann, MD
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Fairfax VA 22030
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Bull, Douglas Middleton, MD
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General Practice

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Bullard, George Minson Jr, MD
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Tabb VA 23602
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Ophthalmology

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Urological Surgery

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Burke, Patrick Kendall, MD
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Pediatrics

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Pediatrics

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Psychiatry

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Internal Medicine

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Child Psychiatry

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Danville VA 24541

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Danville VA 24541
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Manakin Sabot VA 23103
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General Surgery

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Orthopedic Surgery

Cachay, Antonio J, MD
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Otolaryngology

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Richlands VA 24641
Internal Medicine

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1503 Edenburry Dr
Richmond VA 23233
Pediatrics

Cader, Josephine B, MD
1503 Edenbury Dr
Richmond VA 23233
Pediatrics

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Internal Medicine

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Richmond VA 23231
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Gastroenterology

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Richmond VA 23229
Orthopedic Surgery

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Psychiatry

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Emergency Medicine

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Internal Medicine

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General Surgery

Cain, James Steven, MD
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Virginia Beach VA 23464

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Pediatrics

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Hematology

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Internal Medicine

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Family Practice

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Specialty Listing begins on page 259.

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Internal Medicine

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Radiology

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Radiology

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Specialty Listing begins on page 259.

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Specialty Listing begins on page 259.

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Specialty Listing begins on page 259.

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Specialty Listing begins on page 259.

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Clinical Pathology

Specialty Listing begins on page 259.

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Obstetrics/Gynecology

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Specialty Listing begins on page 259.

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Family Practice

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Diagnostic Radiology

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Internal Medicine

Specialty Listing begins on page 259.

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Anatomic/Clinical Pathology

Goodwin, Lyndon Keith, MD
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Radiology

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Family Practice

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Specialty Listing begins on page 259.

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Colon/Rectal Surgery

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Cardiovascular Surgery

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Family Practice

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Portsmouth VA 23707
(804) 393-1009
Nephrology

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Charlottesville VA 22903
General Surgery

Harper, Edwin A, MD
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(804) 384-2677
Pediatrics

Harper, Eugene Jutson, MD
101 N Main St
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(703) 433-2351
General Surgery

Harper, G William III, MD
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(703) 433-9151
Family Practice

Harper, Lisa, MD
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(703) 560-7600
Internal Medicine

Harper, Michael Roy, MD
902 Jonathan St
Woodstock VA 22664
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Family Practice

Harpold, Gary J, MD
Lewis-Gale Clinic Inc
Salem VA 24153
Neurology

Harpole, David H, MD
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(703) 345-7946
Thoracic Surgery

Harr, George Charles, MD
Dermatology of Virginia Beach
Virginia Beach VA 23454
Internal Medicine

Harralson, John David, MD
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(703) 463-7361
Obstetrics/Gynecology

Harrell, Gordon F, MD
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Otolaryngology

Harrell, Robert Riddick, MD
707 Gittings St
Suffolk VA 23434
(804) 539-0251
Urological Surgery

Harrell, William Larry, MD
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Harrelson, Austin B, MD
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Richmond VA 23226
(804) 288-2742
Neurology

Harrer, David S, MD
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Clinical Pathology

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Orthopedic Surgery

Harrington, Randall Leon, MD
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Leesburg VA 22075
Otolaryngology

Harrington, William G, MD
9916 Channing Ln
Richmond VA 23235
Family Practice

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General Practice

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Franklin VA 23851

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Family Practice

Harris, Charles Larry, MD
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Family Practice

Harris, David Lea, MD
Rappahanock Physicians Ct
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Urological Surgery

Harris, David Maxwell, MD
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Bluefield VA 24605
Otolaryngology

Harris, Edward D, MD
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Virginia Beach VA 23451
General Practice

Harris, Gregory Paul Sr, MD
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Anesthesiology

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Dermatology

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General Surgery

Specialty Listing begins on page 259.

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Richmond VA 23220
Neurology

Harris, Joanna H, MD
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Public Health

Harris, Joseph Kim, MD
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Neurology

Harris, L Martin, MD
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Psychiatry

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Emergency Medicine

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Ophthalmology

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General Surgery

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Internal Medicine

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Radiology

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Galax VA 24333
Urological Surgery

Hart, Kirby Thompson Jr, MD
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Petersburg VA 23805
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Pediatrics

Hart, Richard Joseph Jr, MD
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Falls Church VA 22042
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Internal Medicine

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McLean VA 22102
General Surgery

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Psychiatry

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Manassas VA 22110
Ophthalmology

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Radiology

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Internal Medicine

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General Surgery

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Neurology

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Richmond VA 23226
General Surgery

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General Surgery

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Pediatrics

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Oakton VA 22124
(703) 698-3161
Diagnostic Radiology

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Airlie Farm
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Family Practice

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Medical Oncology

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Emergency Medicine

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General Practice

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Psychiatry

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McLean VA 22101
(703) 448-9025
Psychiatry

Heath, Robert C, MD
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Roanoke VA 24014
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Medical Oncology

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Heaton, Roy Earl, DO
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Hematology

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Ophthalmology

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Anesthesiology

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Charlottesville VA 22901
Pulmonary Diseases

Heatwole, Kenneth Michael, MD
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Waynesboro VA 22980
Family Practice

Heatwole, Stanley E, MD
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Staunton VA 24401
(703) 886-7450
Emergency Medicine

Hebron, Desiderio Landas Jr, MD
992 Bragg Rd
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General Surgery

Hecht, Alan, MD
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Internal Medicine

Specialty Listing begins on page 259.

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Norfolk VA 23502
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Gloucester VA 23061

Hecht-Leavitt, Charles M, MD
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Norfolk VA 23508
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Diagnostic Radiology

Heck, Albert William, MD
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Charlottesville VA 22903
Internal Medicine

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Reva VA 22735
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Anesthesiology

Hecker, Carlos Metsch, MD
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Psychiatry

Heda, Tibor, MD
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General Practice

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Hedberg, Eric B, MD
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Danville VA 24541
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Anesthesiology

Heddings, Hazel Jeannette, MD
Theresa Thomas Med Ctr
Ashland VA 23005

Hedges, David Joe, MD
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Family Practice

Hedlund, Linda Margaret, MD
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Falls Church VA 22043
Family Practice

Hedrick, Thomas B, MD
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Family Practice

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Internal Medicine

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Family Practice

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Internal Medicine

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Obstetrics/Gynecology

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Internal Medicine

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Internal Medicine

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Radiology

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Psychiatry

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Henderson, June Rose S, MD
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General Surgery

Henderson, Tabitha Anne, MD
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Urological Surgery

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Otolaryngology

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Pediatrics

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Specialty Listing begins on page 259.

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Richmond VA 23220

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Cardiovascular Diseases

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Pediatrics

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Hand Surgery

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Richmond VA 23226
Internal Medicine

Mc Cue, Raymond L, MD
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Manassas VA 22110
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Obstetrics/Gynecology

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Neurological Surgery

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Anesthesiology

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McLean VA 22101
Child Psychiatry

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Internal Medicine

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Reston VA 22091
Nuclear Surgery

Mc Cutcheon, Randolph Jr, MD
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Mc Daniel, James Lund, MD
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Mc Daniel, Laura Bragg, MD
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Anesthesiology

Mc Daniel, Leroy S, MD
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Pediatrics

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Thoracic Surgery

Mc Daniel, William Windsor, MD
Sewell's Point Branch Clinic
Norfolk VA 23511
Psychiatry

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Otolaryngology

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Internal Medicine

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Mc Dermott, Glenn Robert, MD
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Virginia Beach VA 23464
Internal Medicine

Mc Dill, Phillip Wade, MD
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Emergency Medicine

Mc Donald, David B, MD
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Fairfax VA 22031
Internal Medicine

Mc Donald, Robert M, MD
475 Myers Ave
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Pediatrics

Mc Donald, Ruth Isabel, MD
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Reston VA 22090
Pediatrics

Mc Donald, Thomas D, MD
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Pediatrics

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Psychoanalysis

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Pediatrics

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Hand Surgery

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Mc Dowell, James Everett, MD
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Marion VA 24354
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Family Practice

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Fairfax VA 22032
Ophthalmology

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Obstetrics/Gynecology

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Anesthesiology

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Dermatology

Mc Murrer, James P Jr, MD
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Child Psychiatry

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Richmond VA 23233
Internal Medicine

Mc Murtry, James M, MD
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Urological Surgery

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Mc Neely, Irwin Hollar, MD
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General Practice

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Ophthalmology

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Ophthalmology

Mc Neill, Donald Hanson, MD
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Emergency Medicine

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Family Practice

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Family Practice

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Pediatrics

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Winchester VA 22601
Internal Medicine

Mc Pherson, Milton Lee, MD
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Internal Medicine

Mc Queen, Robert Clarkson, MD
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Diagnostic Radiology

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Specialty Listing begins on page 259

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Internal Medicine

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Psychiatry

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Specialty Listing begins on page 259.

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Medical Oncology

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Psychiatry

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Cardiovascular Diseases

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Clinical Pathology

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Gastroenterology

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Emergency Medicine

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Orthopedic Surgery

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Specialty Listing begins on page 259.

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Radiology

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Internal Medicine

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Medical Oncology

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Urological Surgery

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General Surgery

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Specialty Listing begins on page 259.

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Neurology

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Specialty Listing begins on page 259.

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Specialty Listing begins on page 259.

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Specialty Listing begins on page 259.

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Specialty Listing begins on page 259

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Obstetrics/Gynecology

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Child Psychiatry

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Specialty Listing begins on page 259

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Specialty Listing begins on page 259

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Specialty Listing begins on page 259

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Specialty Listing begins on page 259

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Specialty Listing begins on page 259

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Midlothian VA 23113
Internal Medicine

Zieve, Sandra L, MD
3210 Waterton Dr
Midlothian VA 23113
General Practice

Zikel, Herbert M, MD
115 Woodland Dr
Newport News VA 23606
Family Practice

Zilai, Janet Ann, MD
3514 Columbine Rd
Richmond VA 23234
Internal Medicine

Zilberfarb, Bernard, MD
8310 Shadygrove Cir
Manassas VA 22110
(703) 764-0507
Orthopedic Surgery

Zillhardt, Jacob Charles, MD
Acorn Hill
Fincastle VA 24090
Internal Medicine

Zilliox, Ann Philomena, MD
11835 Fishing Point Dr
Newport News VA 23606
Pediatrics

Zimberg, Gary B, MD
110 Kingsley Ln #401
Norfolk VA 23505
(804) 440-1099
Psychiatry

Zimberg, Stephen, MD
707 Gittings St
Suffolk VA 23434
(804) 539-0251
Obstetrics/Gynecology

Zimberg, Yale H, MD
5855 Bremo Rd #208
Richmond VA 23226
(804) 285-3225
Thoracic Surgery

Zimmer, Bruce Stuart, MD
6300 Stevenson Ave #D
Alexandria VA 22304
(703) 370-9461
Orthopedic Surgery

Zimmer, Timothy James, MD
8919 Three Chopt Rd
Richmond VA 23229
Orthopedic Surgery

Zimmerman, Barklie W, MD
8921 Three Chopt Rd #300
Richmond VA 23229
(804) 285-9416
General Surgery

Zimmerman, Charles H Jr, MD
3116 Victoria Blvd-#204
Hampton VA 23661
(804) 722-7401
Obstetrics/Gynecology

Zimmerman, Harold Baer, MD
3300 Gallows Rd
Falls Church VA 22046
(703) 698-3161
Diagnostic Radiology

Zimmerman, Richard Scott, MD
602 Holbein Pl
Richmond VA 23225
Neurology

Zimmerman, Steven M, MD
636 Sam Snead Ln
Virginia Beach VA 23462
Anatomic/Clinical Pathology

Zimmet, Steven Michael, MD
1400 S Joyce St
Arlington VA 22202
Internal Medicine

Zineski, Stefan Henryk, MD
405 Westwood Office Park
Fredericksburg VA 22401
Internal Medicine

Zinn, Edward, MD
1046 Balls Hill Rd
Mc Lean VA 22101
(703) 524-6942
Psychiatry

Zirkle, Walter M Jr, MD
1041 S Main St
Harrisonburg VA 22801
(703) 434-3831
Obstetrics/Gynecology

Zocco, J James, MD
7107 Jahnke Rd
Richmond VA 23225
(804) 320-2751
Cardiovascular Surgery

Zohn, David Arthur, MD
1515 Chain Bridge Rd
Mc Lean VA 22101
(703) 998-8000
Physical Medicine/Rehabilitation

Zolkiwsky, Walter R, MD
207 E Holly Ave #214
Sterling VA 22170
General Practice

Zonozi, Meer-Said, MD
8519 Rehoboth Ct
Vienna VA 22180
Internal Medicine

Zontine, David Herbert, MD
125-A Medical Cir
Winchester VA 22601
(703) 667-1828
Neurology

Zuckerman, Bram David, MD
5275 Lee Hwy #202
Arlington VA 22207
Internal Medicine

Zuckerman, Ellis N, MD
P O Box 1037
Hopewell VA 23860
(804) 796-9669
Internal Medicine

Zuckerman, Lilly Liu, MD
5275 Lee Hwy #202
Arlington VA 22207-1674
Pediatrics

Zullo, Peter John, MD
Rte 6 Box 7196
Gloucester VA 23061
Internal Medicine

Zurlo, Joseph A, MD
9812 S Park Cir
Fairfax Station VA 22039
Emergency Medicine

Zurowski, Robert David, MD
11723 Bluesmoke Tr
Reston VA 22091

Zuur, Peter James, MD
10 Weston Dr
Staunton VA 24401-1223

Specialty Listing begins on page 259

List of Designated Specialties

Abdominal Surgery
Aerospace Medicine
Allergy
Allergy/Immunology
Anatomic/Clinical Pathology
Anesthesiology
Cardiovascular Diseases
Cardiovascular Surgery
Child Neurology
Child Psychiatry
Clinical Pathology
Clinical Pharmacology
Colon/Rectal Surgery
Dermatology
Diabetes
Diagnostic Radiology
Emergency Medicine
Endocrinology
Family Practice
Forensic Pathology
Gastroenterology
General Practice
General Preventive Medicine
General Surgery
Geriatrics
Gynecology
Hand Surgery
Hand/Neck Surgery
Hematology
Hypnosis
Infectious Diseases
Internal Medicine
Laryngology
Legal Medicine
Medicine Oncology
Neonatal/Perinatal Medicine
Neonatology
Nephrology
Neurological Surgery
Neurology
Nuclear Medicine
Nuclear Surgery
Nutrition
Obstetrics
Obstetrics/Gynecology
Occupational Medicine
Ophthalmology
Orthopedic Surgery
Pediatric Allergy
Pediatric Cardiology
Pediatric Surgery
Pediatrics
Physical Medicine/Rehabilitation
Plastic Surgery
Psychiatry
Psychiatry/Neurology
Psychoanalysis
Public Health
Pulmonary Diseases
Radiology
Rheumatology
Thoracic Surgery
Traumatic Surgery
Urological Surgery

SPECIALTY LISTING OF VIRGINIA PHYSICIANS

Abdominal Surgery

Budding, Jacobus, *Newport News*
Halloran, L Gregg, *Richmond*
Melzig, Eric Perry, *Richmond*
Smith, Oscar Orton Jr, *Marion*
Tauber, Laszlo Nandor, *Alexandria*

Aerospace Medicine

Brandel, George P, *Falmouth*
Camp, Thomas Carl, *Norfolk*
Dehart, Rufus M Jr, *Alexandria*
Dubik, Michael Caryle, *Norfolk*
Gorman, John Rossier, *Virginia Beach*
Horne, Andrew Ferree, *Oakton*
Hudson, David Lindsay, *Richmond*
Knoll, Andrew Mark, *Norfolk*
Moore, Grover L, *Portsmouth*
Stewart, John Robert Jr, *Norfolk*
Turner, Thomas W, *Chesapeake*
Wenzel, Paul David, *Virginia Beach*

Allergy

Babiera, Rodolfo V, *Danville*
Black, Yuill, *Vienna*
Blumberg, Michael Z, *Richmond*
Brownley, Harvey C, *Lynchburg*
Burnett, Gerald Crain, *South Boston*
Catlett, John B, *Richmond*
Faulkner, Donald T, *Norfolk*
Feinstein, Barry K, *Richmond*
Golzar, Nasim, *Richmond*
Guillen, Manuel, *Fairfax*
Hartwright, Alva J, *Newport News*
Helbing, Claus Karl L, *Annandale*
Hyde, Lawrence P, *Pulaski*
Katona, Ildy M, *Arlington*
Laibstain, Herman, *Norfolk*
Lucas, Davis C, *Cloverdale*
Mangold, Harry Armstrong, *Fairfax*
Mc Causland, Alexander, *Roanoke*
Miller, A Larry, *Vienna*
Mohagheghi, Hassan, *Richmond*
Mulllis, Ronald Faison Jr, *Richmond*
Palacios, Henry J, *McLean*
Pangalos, Themis V, *Norfolk*
Park, Il Woo, *Norfolk*
Rosenthal, Richard R, *Great Falls*
Schuster, Donna L, *Herndon*
Smith, Peter Renick, *Fredericksburg*
Statkus, Joseph Kevin, *Norfolk*
Stillwagon, Paul K, *Winchester*
Vilseck, Joseph Richard Jr, *Richmond*
Whitaker, Harry A Jr, *Springfield*
White, Paul Fletcher, *Salem*
Wilbur, Ronald Don, *Springfield*
Wornom, Paul H, *Hampton*

Allergy/Immunology

Carlston, John Anthony, *Virginia Beach*
Hurtado, Rodrigo C, *Alexandria*
Inglefield, Joseph T Jr, *Falls Church*
Leech, Stephen Harry, *Norfolk*
Massie, F Stanford, *Richmond*
Moss, Burton Alan, *Norfolk*
Schwartz, Lawrence Barry, *Richmond*

Anatomic/Clinical Pathology

Abbondanzo, Susan Lucy, *Falls Church*
Abrenio, Jose Kempis, *Grundy*
Albert, Rudolf F, *Roanoke*
Alfonso, Gabriel A, *Radford*
Ammermann, E Gifford, *Salem*
Anderson, Cris Jana, *Portsmouth*
Arretteig, Ulysses Joseph, *Virginia Beach*
Athanasiadou, Panayiota A, *Alexandria*
Athari, Freydoon, *Fairfax*
Avery, Edward S Jr, *Norfolk*
Banchuin, Pornpen S, *Wise*
Bannister, Warren Dale, *Harrisonburg*
Beck, Ralph Edmund, *Richmond*
Belter, Lester Francis, *Mechanicsville*
Binford, Chapman Hunter, *Arlington*
Blumberg, Andrea Klein, *Richmond*
Bodnar, James Patrick, *Richmond*
Borland, David S, *Williamsburg*
Bowers, Henry M Jr, *Alexandria*
Boyd, James C, *Charlottesville*
Brennan, Gloria G, *Fairfax*
Broecker, Anna M H, *Richmond*
Brown, Margaret Ann, *Fairfax*
Bruce, Daniel William, *Fairfax*
Buddington, R S, *Abingdon*
Bush, Leah L, *Richmond*
Callicott, Joseph H Jr, *Lynchburg*
Caplan, Carol Miegel, *Hampton*
Carpenter, Richard H, *Richmond*
Carroll, George Joseph, *Suffolk*
Carson, Thomas H, *Roanoke*
Ceballos, Josefino M, *McLean*
Chang, Amos H, *Virginia Beach*
Chang, Wei Liang, *Lynchburg*
Cheng, Chin-Lin, *Bristol*
Chrea, Siphath, *Alexandria*
Chu, Tu-Anh, *Arlington*
Clark, Richard Franklin, *Hampton*
Coffelt, Kenneth Clayton, *Martinsville*
Cook, Charles Barrie, *Falls Church*
Cook, Sallie S, *Rockville*
Cooper, Philip H, *Charlottesville*
Cordray, Douglas Roy, *Portsmouth*
Cresson, David H Jr, *Lynchburg*
Crosby, James Foster, *Chesapeake*
Cuzzocrea, Anthony D, *Roanoke*
D'Amato, Nicholas Anthony, *Norfolk*
Darcy, Teresa Paulsen, *Arlington*
Dauber, Henry, *Fairfax*
David-Nelson, Margit A, *Springfield*
Davis, Frederick Carr, *Newport News*
Deblois, Georgean G, *Richmond*
De Simone, Ralph S, *Annandale*
Dolan, William David Jr, *Arlington*
Duncan, Phillip Bentley, *Richmond*
Dunn, Harold Paul, *Richmond*
Duong, Hung Dinh, *Dunn Lurray*
Dutz, Werner, *Richmond*
Dutz-Kohout, Elfriede, *Richmond*
Eliezer, Elaine Teresa, *Leesburg*
Enos, William F III, *Vienna*
Estevez, Jose M, *Danville*
Fabich, Douglas R, *Falls Church*
Faulconer, Robert Jamieson, *Norfolk*
Faustino-Tataje, Benigno D, *Radford*
Fechner, Robert Eugene, *Charlottesville*
Feldman, Philip S, *Charlottesville*
Field, Frances Patricia, *Arlington*
Frable, William Jackson, *Richmond*
Franco, Andres P Jr, *Aylett*
Franquemont, Douglas William, *Charlottesville*
Frierson, Henry Franklin Jr, *Charlottesville*
Fulenwider, Ann K, *McLean*
Gala, Hemlata Kantilal, *Charlottesville*
Gale, James Cofer, *Roanoke*
Garcia, Susan Maria, *Richmond*
Genta, Valerio M, *Virginia Beach*
Gerszten, Enrique, *Richmond*
Ghatak, Nitya R, *Richmond*
Godwin, Ira David, *Fairfax*
Goldes, Jeffry A, *Alexandria*
Gonias, Steven Larry, *Charlottesville*
Gonzales, Manuel B, *Petersburg*
Goodwin, Ambler Ray, *Norfolk*
Graber, Stanley Jr, *Virginia Beach*
Gray, Lloyd Sherwood, *Charlottesville*

Anatomic/Clinical Pathology *(cont'd)*

Graybeal, Frederick Quincy Jr, *Marion*
Griffin, Harvey Lee Jr, *Petersburg*
Grisales, Asur III, *Danville*
Groff, Warren Sterling, *Portsmouth*
Groot Bluemink, Gary Jr, *Norfolk*
Guanzon, Noel A, *Tazewell*
Guin, Grace Hughes, *Arlington*
Gutbezahl, Cary David, *Norfolk*
Gutierrez, Fabio E, *Richmond*
Hadfield, Milton G, *Richmond*
Hamrick, Frederick D III, *Lynchburg*
Hard, Richard C Jr, *Richmond*
Hardy, Thomas J, *Danville*
Hefter, Lawrence G, *Falls Church*
Hellinger, Karl H R, *Fairfax*
Helwig, Warren Bowman, *Zanoni*
Herman, Mary Margaret, *Charlottesville*
Herrington, John B III, *Richmond*
Hershberg, Robert A, *Richmond*
Hine, Paul Forrest, *Fredericksburg*
Hoke, Harry Franklin, *Richmond*
Holthaus, Wallace Harold, *Harrisonburg*
Honablue, Valrie M, *Williamsburg*
Hostetter, Alden Lynn, *Fairfax*
Houk, Russell R, *Alexandria*
Hsiu, Jeng-Gwang, *Norfolk*
Hu, Anthony Wen-Shih, *Midlothian*
Hubbard, Elizabeth Willy, *Charlottesville*
Hunter, Samuel Boykin, *Richmond*
Innes, Donald John Jr, *Charlottesville*
Jilly, Pongrac Nicholas, *Arlington*
Johnston, Charles L Jr, *Richmond*
Josefiak, Eugene Joseph, *Roanoke*
Kay, Saul, *Richmond*
Kelsey, Ronald Leon, *Fredericksburg*
Kerman, Shelly Lynn, *Fairfax*
Kim, Kil Seong, *Suffolk*
King, Peter Gabriel, *Fairfax*
Kipreos, Barbara Ekker, *Richmond*
Klimock, Gregory, *Wicomico*
Koh, Hae Kyung, *Poquoson*
Kornstein, Michael Jeffrey, *Richmond*
Kramer, William, *Richmond*
Krueger, John Jay, *Virginia Beach*
Ladaga, Leopoldo Elio, *Virginia Beach*
Langebeck, Miguel, *Blacksburg*
Lawrence, Jeffry Brian, *Midlothian*
Lee, Jesse Thomas III, *Waynesboro*
Legier, Jacques F, *Newport News*
Leonhardt, Hannah V, *Danville*
Lineberger, Adrian Smith, *Fairfax*
Linn, James John, *McLean*
Lippman, Harry R, *Richmond*
Long, Alvin Penrose Jr, *Portsmouth*
Lovell, Mark Alan, *Charlottesville*
Macasaet, Francisco Friginal, *Colonial Heights*
Mac Millan, R Hunt III, *Charlottesville*
Madalengoitia, Jose, *Clifton Forge*
Maddox, John Coulter, *Newport News*
Madison, Jennifer Frith, *Charlottesville*
Makoui, Cyrus, *Salem*
Martens, Vernon Edward, *Haywood*
Martin, Franklin Jr, *Wachapreague*
Massello, William III, *Roanoke*
Mayer, William Dixon, *Norfolk*
Mayes, Daniel Charles, *Charlottesville*
Mc Coy, Kenneth Lowell, *Syria*
Meier, Frederick Augustus, *Richmond*
Mensch, Arthur H, *Alexandria*
Mikhail, Eva L, *Springfield*
Miller, Deborah Kay, *Chantilly*
Mills, Alan S, *Richmond*
Mills, Stacey E, *Charlottesville*
Mohanty, Laxmi B, *Richmond*
Moncure, Charles W, *Richmond*
Monroe, Stuart Alan, *Winchester*
Moran, Thomas James, *Danville*
Moriarty, Richard P, *Chesapeake*
Morrison, A Glenn, *Harrisonburg*
Morrison, Arna Glenn, *Harrisonburg*
Morrison, Ashton B, *Norfolk*
Munsie, William Johnson, *Fredericksburg*
Murphy, George Herman, *Winchester*
Nakoneczna, Irene, *Richmond*
Nash, Howard R, *Pamplin*
Netto, Molly, *Poquoson*
Neumann, Mary P, *Alexandria*
Nguyen-Tong, Henriette, *Arlington*
Niskanen, Eero O, *Charlottesville*
Nocon, Emma C, *Alexandria*
Norling, Laura Lee, *Charlottesville*
O'Connell, Clifford Thompson, *Hampton*
O'Connell, Patrick, *Winchester*
Oldmixon, Willard J, *Arlington*
Orlando, Michael M, *Warrenton*
Oxley, David W, *Roanoke*
Palmer, Richard Nash, *Arlington*
Parikh, Nipun O, *Forest*
Park, Sung C, *Roanoke*
Pastore, Lucia, *Falls Church*
Patel, Kantilal D, *Richlands*
Patterson, Robert Harry, *McLean*
Patterson, William M, *Davis Wharf*
Pearce, Leroy S, *Richmond*
Perez, Antonio, *Radford*
Perry, John Michael, *Lynchburg*
Petoe, George, *Williamsburg*
Piggott, James Albert, *Lynchburg*
Pinto, Carlos, *Suffolk*
Pittman, Jackson Lee, *Roanoke*
Poleksic, Slobodan III, *Williamsburg*
Pooley, Robert Earl, *Roanoke*
Presswalla, Faruk B, *Norfolk*
Price, Linda McWey, *Richmond*
Quintos, Eugenia J, *Alexandria*
Rajurkar, Suman Madhusudan, *Virginia Beach*
Ramos, Remigio Mayuga, *Chesapeake*
Reagin, David Earl, *Alexandria*
Reynolds, John W, *Richmond*
Ricardo, Raymond C, *Williamsburg*
Rice, Diane Beach, *Vienna*
Richardson, Don H, *Winchester*
Riddick, Joseph H Jr, *Chesapeake*
Riedy, Dawn Kathleen, *Charlottesville*
Roberts, James B, *Richmond*
Rosenblum, William I, *Richmond*
Ross, Denise G, *Virginia Beach*
Ross, William B, *Virginia Beach*
Roycroft, David William, *Martinsville*
Russi, Simon, *Alexandria*
Rust, John Newton, *Marion*
Santoyo Lopez, Jesus A, *Manassas*
Schatzki, Peter Ferdinand, *Richmond*
Schnell, Donald E, *Pulaski*
Schroeder, Andrew George, *Sandston*
Schwartzman, Joseph D, *Charlottesville*
Seal, Robert B, *Portsmouth*
Sennesh, Joel David, *Falls Church*
Shah, Nalin G, *Norton*
Sheikh, Nasreen Mazhar, *McLean*
Shen, Mary Catherine, *Chesapeake*
Sherman, Nathan, *Vienna*
Siegmund, Brad Thomas, *Colonial Heights*
Silberman, William C, *Leesburg*
Simon, Michelle Louise, *Fairfax*
Singer, Gerard Anthony, *Chesapeake*
Singh, Mridula, *Mc Lean*
Sinnenberg, Robert James, *Richmond*
Skovronsky, Jeffrey J, *Fairfax*
Smith, Gladstone Edward Jr, *Richmond*
Smith, Ray Mckean III, *Norfolk*
Smith, Robert Lawrence, *Virginia Beach*
Spahr, John, *Waynesboro*
Sperber, Edward Ephraim, *Portsmouth*
Sproul, A Erskine, *Staunton*
Stay, Ellsworth J, *Arlington*
Stefanini, Mario, *Richlands*
Steingaszner, Laszlo C, *Woodbridge*
Stephens, Ralph Rousseau, *Norfolk*
Sturgill, Benjamin C, *Charlottesville*
Summerville, John William, *Glen Allen*
Sutingco, Nicanor C, *Hampton*
Swedo, Gregory J, *Alexandria*
Sylvest, Vernon Martin, *Richmond*
Talbot, William Hanna, *Harrisonburg*
Teja, Kuldeep, *Charlottesville*
Thomas, Carolyn E, *Richmond*
Thomas, George Walter, *Richmond*
Thomas, Wilbur Clyde, *Winchester*
Thorne, Willes Max, *Herndon*
Thornhill, Thomas M Jr, *Lynchburg*
Thornton, John L, *Richmond*
Tillack, Thomas W, *Charlottesville*
Todd, William McClintock, *Richmond*
Tong, Nguyen Thanh, *Arlington*
Torre, Anthony Vincent, *Salem*
Torre, Wayne Joseph, *Salem*
Tucker, Forrest L, *Roanoke*
Turkus, Joan A, *Alexandria*
Turner, Jack Cocke, *Danville*
Urueta T, Enrique E, *South Boston*
Vandenberg, Scott Russel, *Charlottesville*
Vassallo, Michael, *Fairfax*
Vennart, George P, *Richmond*
Via, C Timothy, *Roanoke*
Vinh, Tuyethoa Nguyen, *Fairfax*
Wakely, Paul Ellis Jr, *Richmond*
Ward, Emily Wofford, *Norfolk*
Warren, Thomas N, *Clifton Forge*
Weiss, Daniel Leigh, *Alexandria*
Werner, Alice Laibstain, *Norfolk*
White, Hubert Ruark Jr, *Richmond*
White, Robert M, *Roanoke*
Whitehurst, Robert M, *Roanoke*
Whittle, Thomas S Jr, *Galax*
Williams, Anderson James Jr, *Norfolk*
Williams, Andrew Lee, *Marion*
Wray, Michael Doran, *Richmond*
Yoneyama, Tatsuo, *Salem*
Zimmerman, Steven M, *Virginia Beach*

Anesthesiology

Abenes, Gil A, *South Boston*
Abramowitz, Michael D, *Falls Church*
Adamonis, Alan James, *Yorktown*
Aghdami, Aliasghar, *Richmond*
Ahn, Keung Sup, *McLean*
Ahn, Kyung Mi, *McLean*
Alerte, Marie Claude Aurubin, *Hampton*
Ali, Rukhsana Fatima, *Chesterfield*
Anderson, Andrew Stephen, *McLean*
Anderson, George E, *Fredericksburg*
Andrews, K P, *Charlottesville*
Andrews, Patricia M, *Charlottesville*
Apostle, Thomas Christ, *Winchester*
Arnold, William P III, *Charlottesville*
Arriola-Roda, Elma Lou, *Tappahannock*
Atkinson, Leigh Oliver, *Salem*
Ayscue, Quincy Adams, *Norfolk*
Baber, Bruce Allenby, *Hampton*
Baetz, William R, *Roanoke*
Bailey, Steven Leroy, *Virginia Beach*
Bajit, Marieta Agawin, *Norfolk*
Bajwa, Manjit Rajinder, *McLean*
Balestrieri, Francis Joseph, *Arlington*
Balingit-Gonzales, Purita E, *McLean*
Ball, John Edward, *Alexandria*
Baron, George P, *Salem*
Barth, Robert Lewis, *McLean*
Basile, Vincent T, *Roanoke*
Bass, William P, *Bristol*
Bell, Solomon Z, *Norfolk*
Bellotti, Gerald A, *Fredericksburg*
Berish, Robert Frank, *Falls Church*
Berry, Frederic A, *Charlottesville*
Bertram, Susan Gail, *Virginia Beach*
Billue, Angela Renee, *Glen Allen*
Bindal, Rajinder Kumar, *Annandale*
Blankenbaker, Walter L, *Charlottesville*
Blum, Charles Timothy, *Newport News*
Boaz, Beverly G Jr, *Petersburg*
Bohannon, Thomas William, *Richmond*
Boos, Donald Lewis Jr, *Charlottesville*
Bowles, Edward Miller Jr, *Covington*
Boyan, Charles P, *Richmond*
Brein, Jonathan R, *Norfolk*
Brodie, Stephan Barry, *Reston*
Brodsky, Ronald Clarke, *Norfolk*
Brothers, William George, *Newport News*
Brown, Carlton Quentin, *Reston*
Brown, William P, *Virginia Beach*
Brusino, Francis Gregory, *Virginia Beach*
Bryan, Louis, *Annandale*
Bryant, John E Jr, *Franklin*
Buenaventura, Frank A, *Alexandria*
Burke, Melvin H, *Norfolk*
Bush, Richard G, *Chesapeake*
Cabigao, Olivia Ordona, *Danville*
Caligtan, Emma Alvaro, *McLean*
Callari, Giulio, *Arlington*
Candler, Eric Michael, *Chesapeake*
Cardwell, Charles P, *Richmond*
Carlson, Daniel W, *Virginia Beach*
Carlucci, Joseph, *Norfolk*
Carmichael, Elizabeth R, *Rixeyville*
Carney, David A, *Newport News*
Carter, Henry G, *Norfolk*
Cason, Lewis P, *Marshall*
Centenera, Judy S, *Arlington*
Chalam, Ramesh, *Harrisonburg*
Chalasani, Srirama Prasad, *Virginia Beach*
Chaldares, Louis S, *Waynesboro*
Chen, Chun-Ming, *Portsmouth*
Chen, Jen-Wen, *Arlington*
Chen, Jin Sheng, *Chester*
Chin, May Lin, *Vienna*
Chkoski, Peter Frederick, *Williamsburg*
Cho, Dai Ho, *McLean*
Choi, Moon Jung, *McLean*
Choudhry, Yasmin Arshed, *Great Falls*
Choy, Yoon Keun, *Portsmouth*
Christian, William E, *Radford*
Chung, Jey-Dea, *Radford*
Chung, Kyung Yil, *Alexandria*
Clapp, Henry W Jr, *Franklin*
Clark, Joe Francis, *Roanoke*
Claustro, Daisy Senen, *Richlands*
Clougherty, Patrick William, *Vienna*
Cohen, Alan Paul, *Hampton*
Cole, Waverly Manson, *Richmond*
Comar, James Shine, *Waynesboro*
Conway, Kevin, *Roanoke*
Cooper, Charles Morgan, *Charlottesville*
Couper, John L, *Lexington*
Couper, John Lee, *Lexington*
Coury, George S, *Roanoke*
Coutinho, Pamela Enid, *McLean*
Creasy, Richard A, *Winchester*
Creteur, Christian E, *Portsmouth*
Crisci, Lorraine, *Richmond*
Cudworth, George Hitchon, *Fincastle*
Dakermandji, Farid, *Clifton Forge*
D'Alessandro, Frank T, *Charlottesville*
Dallas, Robert L, *Roanoke*
Dalton, Claudette Ellis, *Charlottesville*
Davis, John Edward III, *Winchester*
Deacon, James Douglas, *Waynesboro*
Debnath, Kiran Sankar, *Portsmouth*
Delaney, Allen Glover, *Reston*
Delaney, John P, *Roanoke*
Delaney, Michael D, *Alexandria*
Delaney, Thomas J, *Lynchburg*
Del Pilar, Leticia C Q, *Catharpin*
Depadua, Laurel Garcia, *Hampton*
Desmarteau, John Kenton, *Leesburg*
Di Fazio, Cosmo Americo, *Charlottesville*
Donegan, Martha F, *Lynchburg*
Duckworth, Elizabeth H, *Roanoke*
Duggar, Robert G Jr, *Roanoke*
Durbin, Charles G Jr, *Charlottesville*
Edillon, Guido Artes, *Roanoke*
Ellis, Robert, *Richmond*
Elsten, Jane Linda, *McLean*
Epstein, Robert M, *Charlottesville*
Erb, Alfred William, *Burke*
Erdim, Feyyaz, *Roanoke*
Escario, Francisco T, *Woodbridge*
Escario, Margarito T, *Danville*
Escobar, Prospero S, *Williamsburg*
Esmaili, Hossain, *Franklin*
Espinosa, Emilio M, *Suffolk*
Estes, Michael D, *Richmond*
Etheridge, Charles Layton, *Norfolk*
Fabian, Judith A, *Richmond*
Faul, Lloyd Joseph Jr, *Norfolk*
Fauss, Brent G, *Richmond*
Feria, Argelio A, *Richmond*
Fineman, Sheldon Paul, *Virginia Beach*
Fingerhut, Herbert Wise Jr, *Reston*
Fryer, Lois Fox, *Portsmouth*
Futterman, Craig Alan, *Falls Church*
Gal, Thomas J, *Charlottesville*
Gandy, Charles Lewis III, *Arlington*
Garcia, Ramon, *Falls Church*
Gaspar, Patrick Sunderraj, *Richmond*
Gellman, Michael D, *Portsmouth*
Ghaphery, James Louis, *Richmond*
Gibson, William Russell, *Norfolk*
Gilbert, Timothy Bruce, *Arlington*
Gillinson, Roy Stuart, *Alexandria*
Gilmer, Robert D, *Abingdon*
Goldman, Arthur Joel, *Poquoson*
Gonzales, Manuel Falcon, *McLean*
Grantham, Christopher D, *Abingdon*
Grewal, Tejinder S, *Hopewell*
Griffeth, James Kenneth, *Galax*
Grubb, William R, *Arlington*
Gunn, James Wallace, *Fredericksburg*
Gustafson, Judy S, *Roanoke*
Hagan, Charles H, *Winchester*
Hague, Frank Joseph, *Roanoke*
Hamill, James F, *Newport News*
Hamill, Robin J, *Charlottesville*
Hanson, George K, *Hampton*
Harris, Gregory Paul Sr, *Winchester*
Hassan, Meborah, *Arlington*
Hatchett, John Franklin, *Richmond*
Heatwole, John Paul, *Waynesboro*
Heckel, C Gordon, *Reva*
Hedberg, Eric B, *Danville*
Hess, John Milton, *Norfolk*
Heyneker, Theodore Johan, *Purcellville*
Hill, Alvin Joseph, *Reston*
Hira, Kamla Chandramani, *Rosslyn*
Hite, P David, *Richmond*
Holland, Walter R, *Lynchburg*
Holroyd, Timothy J, *Virginia Beach*
Holt, Ronald R, *Falls Church*
Hong, Seung Kook, *Vienna*
Hoover, Herbert C, *Petersburg*
Hranowsky, Nicholas P, *Richmond*
Hsu, Jong C, *Chester*
Hubert, Juergen, *Rjichmond*
Hudson, Joanne C, *Richmond*
Huff, William T Jr, *Alexandria*
Hunt, David Sterling, *Roanoke*
Hurt, David L, *Williamsburg*
Hurt, Terry Lynne/Wright, *Richmond*
Hwu-Yun, Rosanna Wan-Rou, *Fairfax*
Isenhower, Nelson N, *Winchester*
Jackson, Randolph M, *Winchester*
Janes, John R Jr, *Richmond*
Jarrett, Alvin Quarles, *Virginia Beach*
Javate, Rosy T, *McLean*
Jennette, Arthur Harris, *Norfolk*
Jeroy, Harry Keirn, *Virginia Beach*
Johns, Roger A, *Charlottesville*
Johnston, Russell Graybill, *Virginia Beach*
Jonas, John F, *Forest*
Jones, Beverly, *Midlothian*
Jones, John R, *Richmond*
Jordan, David Lee, *Roanoke*
Kahana, Madelyn Dale, *Charlottesville*
Kallar, Surinder Kaur, *Richmond*

Anesthesiology *(cont'd)*

Kancler, Erika N, *Waynesboro*
Kanithanon, Pitplearn, *Hot Springs*
Kao, Zen Leu, *Petersburg*
Kaplan, Roy Michael, *Norfolk*
Keenan, Richard Leo, *Richmond*
Kennedy, Stephen F, *McLean*
Kent, Richard Irwin, *Williamsburg*
Keshmiri, Abolhasan, *Woodbridge*
Kezar, Edwin Paul, *Portsmouth*
Khan, Abdul Hadi, *Pulaski*
Kim, Moon Chul, *Richmond*
Kim, Suk Kew, *Great Falls*
Kim, Young Duk, *McLean*
King, Joseph Aaron, *McLean*
King, Mervyn R, *Fieldale*
Kirby, Mathis Ann, *Richmond*
Kistner, James Robert, *Roanoke*
Klein, David S, *Staunton*
Koch, Fred, *Charlottesville*
Koch, James Frederick, *Falls Church*
Kohring, Regis Clarke, *Harrisonburg*
Korbon, Gregg Allen, *Charlottesville*
Kravetz, Robert Alan, *Fredericksburg*
Kroll, Alan David, *Colonial Heights*
Kwong, Wai Hong, *Suffolk*
Lake, Carol Lee, *Charlottesville*
Lam, Gene N, *Virginia Beach*
Lander, Christopher John, *Charlottesville*
Lanzara, Gennard Thomas Jr, *Roanoke*
Laviano, Trent, *Earlysville*
Lawande, Rekha R, *Manassas*
Lawson, Dan, *Charlottesville*
Lee, Chao-Te E, *Poquoson*
Lee, Duk-Hyun, *Portsmouth*
Lee, Jai Keun, *Fairfax*
Lee, Lucia Soondong, *Richmond*
Lee, Moon Kun, *Fairfax*
Lee, Victor Chia-Vee, *Charlottesville*
Lee-Chun, Lucia S, *Richmond*
Legaspi, Alfredo L, *Falls Church*
Legaspi, Amante G Jr, *Chesapeake*
Leich, Julius Keith, *Midlothian*
Lesko, Edmund Michael, *Rocky Mount*
Levin, Laurence L, *Virginia Beach*
Li, Si-Ju, *Alexandria*
Lichtmann, Albert Laszlo, *McLean*
Lim, Henry Suh, *Norfolk*
Lin, Allen Y, *Danville*
Lin, Yi-Shien, *Danville*
Linas, Philip A, *Glen Allen*
Littlehale, Robert Ferguson, *Norfolk*
Litwiller, Roger Wayne, *Roanoke*
Lopez, Roberto V, *Richmond*
Lowry, Eleanor K, *Lynchburg*
Luna, Ma Lourdes G, *Fredericksburg*
Lynch, Carl III, *Charlottesville*
Mac Cormac, Michael L, *Lynchburg*
Machaj, Vincent Richard, *Virginia Beach*
Mac Lellan, John F, *Weems*
Manheim, Arnold, *Danville*
Manitsas, Hildegard W, *McLean*
Marino, John James, *Winchester*
Maroto, Felix, *Norfolk*
Martinez, Horacio Duarte, *Charlottesville*
Matchett, Robert Michael, *Virginia Beach*
May, Boyd H Jr, *Richmond*
Mc Cune, Frederick K, *Virginia Beach*
Mc Daniel, Laura Bragg, *Virginia Beach*
Mc Kay, Ralph James, *Bluefield*
Mc Millin, Philip W, *Richmond*
Meadows, James C, *Richmond*
Meeks, Charles H, *Irvington*
Midis, Panos M, *Richmond*
Molera, Federico F, *Nassawadox*
Moncure, William B, *Water View*
Mondino, Marta Del Valle Mansilla, *McLean*
Monteiro, Ildefonso C, *Richmond*
Montgomery, Margaret Thomas, *Richmond*
Moon, Sung Kil, *McLean*
Moran, Raul Abalos, *Springfield*
Morris, John Franklin, *Lynchburg*
Morriss, Albert W, *Staunton*
Moschella, Ralph III, *Alexandria*
Mudrick, Paul R, *Lynchburg*
Murthy, Papaiah Srinivas, *Virginia Beach*
Myint, Maung T, *Suffolk*
Naderi, Mohamad Sirus, *Chester*
Nakatsuka, Mitsuru, *Midlothian*
Nguyen, Khoa Quoc, *Annandale*
Nguyen, Tan Phuong, *Hampton*
Niederlehner, James R, *Roanoke*
Norton, Richard Howard, *Virginia Beach*
Novo, Antonio Miguel, *Richmond*
Novoa, Ralph R, *Hampton*
Nuqui, Luzviminda V, *Williamsburg*
Ochsner, Frederick C III, *Lynchburg*
O'Connor, John J, *Centreville*
Olenczak, John Edward, *Norfolk*
Oliver, Francis Theodore, *Farmville*
Owen, Heth Jr, *Glen Allen*
Pak, Yong Kun, *Richmond*
Pang, Kam-Fai, *Richmond*
Park, J H John, *Roanoke*
Park, Sung G, *Richmond*
Parrish, Glenn Cade, *Fredericksburg*
Passantino, Giuseppe Jr, *Norfolk*
Patel, Surendra R, *Portsmouth*
Peacock, Ronald Everett, *Locust Grove*
Peck, Randall Joseph, *Culpeper*
Pecsok, James Louis, *Virginia Beach*
Peereboom, Maud, *Fairfax*
Penhallurick, William J, *Norfolk*
Peotrowski, Richard Francis, *Midlothian*
Perera, Francis, *Richmond*
Peresleny, Vendel I, *Fredericksburg*
Perez, Antonio III, *Roanoke*
Petersen, William Carl, *Virginia Beach*
Phillips, George Lauren, *Strasburg*
Phillips, Richard B, *Chesapeake*
Pinsker, M Craig, *Richmond*
Poling, Harry Emerson, *Winchester*
Pope, Benjamin Wood, *Richmond*
Price, Philip Ashley, *Arlington*
Quetulio-Del Pilar, Leticia C, *Manassas*
Rafajac, Franjo, *Norfolk*
Rafii, Amir, *Richmond*
Rah, Kang H, *Richmond*
Rangappa, Jai Kumar, *Hampton*
Rapp, Raymond Edward, *Harrisonburg*
Razvi, Mir Basharath Ali, *Great Falls*
Rebman, John III, *Richmond*
Rector, George Harry Morris, *Norfolk*
Reid, Stephanie Theros, *Gainesville*
Remandaban, Teodulo, *Roanoke*
Ribeiro, Gilbert, *Falls Church*
Ricardo, Luzviminda, *Williamsburg*
Rich, George Frederick, *Charlottesville*
Rinne, Paul Walter, *Radford*
Rivers, Richard John, *Charlottesville*
Rooney, M S, *Richmond*
Ross, Vernon Horace, *Midlothian*
Ross, William Tyler Jr, *Charlottesville*
Rowlingson, John Clyde, *Charlottesville*
Rucker, Edmund Harrison, *Newport News*
Rudzinski, Dennis J, *Richmond*
Ruiz, Abelardo A Jr, *Virginia Beach*
Ruiz-Camauer, Raul, *McLean*
Rushia, Edwin L, *Charlottesville*
Russell, Michael W, *Culpeper*
Said-Hanna, Sawsan, *Annandale*
Salazar, Delfin B, *Oakton*
Salomonsky, Anita B, *Richmond*
Santiago, Arthur C, *Virginia Beach*
Santos, Amelia Limcaco, *Norfolk*
Satko, Frank Gregory, *Portsmouth*
Sawyer, Lois Taylor, *Williamsburg*
Scheidlinger, Jeffrey Alan, *Falls Church*
Schettini, Alfonso, *Richmond*
Schkolnik, Ronaldo, *Arlington*
Schoeffel, Mark E, *Charlottesville*
Schriemer, Paula Boigegrain, *Charlottesville*
Schroeder, Jonathan Scott, *Midlothian*
Schwenzer, Karen Jean, *Charlottesville*
Senfield, Richard Maxon, *Harrisonburg*
Shabb, William A, *Winchester*
Shah, Rakesh Kumar, *Woodbridge*
Shakoor, Mohammed A, *Great Falls*
Shelat, Vipul N, *Manassas*
Sherban, Kenneth A, *Lynchburg*
Shim, Chi Yun, *Richmond*
Sibay, Hassan, *Mc Lean*
Silbersiepe, Barbara Kromer, *Catlett*
Silbersiepe, Heinz-Otto, *Catlett*
Silbersiepe, Kathryn Ann, *Richmond*
Singh, Harinder P, *Richmond*
Sirh, Joseph Hongsuk, *Clifton*
Skurdal, David Nelson, *Alexandria*
Slijepcevic, Sinisa, *McLean*
Smith, Arthur Richard, *Alexandria*
Smith, Bobby L, *Norfolk*
Souza, Cesar Augusto, *South Boston*
Soyangco, Alfredo Lopez, *Danville*
Sprissler, Greg T, *Falls Church*
Stewart, Thomas Woodruff, *Lynchburg*
Stickley, William S, *Harrisonburg*
Stiner, Allan E Jr, *Virginia Beach*
Stirt, Joseph Avrum, *Charlottesville*
Stone, David J, *Charlottesville*
Story, William Henry, *Harrisonburg*
Stough, Robert C, *Roanoke*
Su, Jiin-Shiang, *Alexandria*
Su, Robert K, *Portsmouth*
Sublett, James Wilson Jr, *Lynchburg*
Summerlin, Daniel Clayton Jr, *Salem*
Swann, Louis William Jr, *McLean*
Swezy, Nisha Johari, *Blacksburg*
Szele, George, *Oakton*
Tanaka, Zenji, *Portsmouth*
Tanbonliong, Benedict Ong, *Wise*
Tanner, William Woodrow, *Richmond*
Tantongco-Yu, Maria S, *Annandale*

Anesthesiology *(cont'd)*

Tausig, Daniel, *Richmond*
Temple, James Edmond, *Richmond*
Temucin, Oguz, *Alexandria*
Thein, Richard M H, *Suffolk*
Thomas, P Varkey, *Norfolk*
Threlfall, John E, *Falls Church*
Thung, Nalda Sylvia, *Petersburg*
Tilson, Michael Wayne, *Alexandria*
Ton, Chau That, *Vienna*
Tran, Dung Quoc, *McLean*
Trimarchi, Albert J, *Blacksburg*
Trimmer, Karen Rae, *Newport News*
Trostle, Thomas F, *Boones Mill*
Tsao, Ming Jyi, *Colonial Heights*
Tsui, Edward S, *Danville*
Turkekul, Fuat, *Springfield*
Ullman, James Irwin, *Hampton*
Van Osten, George K, *Winchester*
Vance, John Hale, *Richmond*
Verhey, Martin J, *Roanoke*
Vesuna, Cyrus, *Vienna*
Virtudes, Julieta Ong, *Fairfax*
Vitaliti, Constance Jean, *Richmond*
Vitaliti, John C, *Falls Church*
Ward, Charles Arthur, *Norfolk*
Weimer, George A, *Powhatan*
Wenleder, Rudolf B, *Richmond*
Wenzinger, Elaine M Kimmel, *Front Royal*
Wenzinger, Patrick Joseph, *Front Royal*
West, David Martin, *Norfolk*
White, James Lee, *Alexandria*
Whitley, Mary Leitschuh, *Arlington*
Whitney, Hugh H, *Virginia Beach*
Wild, Charlotte, *Newport News*
Wilder, Charles D, *Virginia Beach*
Wilhite, Anne O'Brien, *Richmond*
Wilkin, Olive C, *Richmond*
Williams, McKim, *Newport News*
Williamson, Robert J, *Lynchburg*
Wilson, Cathy Jo, *Charlottesville*
Wilson, James Jr, *Hampton*
Wilson, Reina Macariola, *Arlington*
Windle, Charles Beverly, *Virginia Beach*
Wolman, Richard Lee, *Richmond*
Woodside, Jack R, *Fairfax*
Work, Granville B III, *Norfolk*
Yeh, Li-Cheng, *Petersburg*
Yoo, Hee Dong, *Virginia Beach*
Yoon, Hang Jin, *Reston*
Youn, Young-Ok, *Richmond*
Yu, Charles Chua, *Annandale*

Cardiovascular Diseases

Ahmed, Syed Aftab, *Danville*
Austin, Joseph Lee, *Roanoke*
Baird, Charles Lewis Jr, *Richmond*
Banian, Barkev H, *Woodbridge*
Bartel, Alan Gilbert, *Norfolk*
Baskerville, A L, *Richmond*
Bennett, Robert M, *Richmond*
Blount, Alston Wilcox, *Richmond*
Bon Tempo, Carl Prescott, *Annandale*
Bowen, Courtney C, *Richlands*
Brewer, Herbert Martin, *Norfolk*
Brown, James Dixon, *Winchester*
Call, Thomas David, *Norfolk*
Callaghan, William E, *Virginia Beach*
Carpousis, Dean P, *Arlington*
Chou, Yi-Nan, *Hopewell*
Chough, Dae Been, *Chesapeake*
Ciuffo, Allen A, *Norfolk*
Crafford, William A Jr, *Radford*
Davidov, Michael E, *Falls Church*
Davies, Douglas A, *Harrisonburg*
Davis, Stephen V, *Danville*
Diasio, Joseph S, *Richmond*
Dickinson, William Andrew, *Virginia Beach*
Dietz, Richard F Jr, *Arlington*
Dixon, Henry Bryon II, *Nassawadox*
Drew, Donald W, *Norfolk*
Dunnington, Gansevoort H, *Richmond*
Eapen, George, *Emporia*
Espejo, Guillarmo Jr, *Virginia Beach*
Farra, Frederic T, *Winchester*
Feild, Bolling Jones, *Petersburg*
Fitzgerald, John E, *Richmond*
Francis, Cleveland Jr, *Alexandria*
Friend, Christopher D, *Charlottesville*
Futral, Allen Ashley Jr, *Winchester*
Gaddy, Clifford Garland, *Danville*
Gear, Arthur Sewell, *South Hill*
Goldberg, Martin J, *Norfolk*
Goldman, Stanley Allen, *Richmond*
Griffin, John J Jr, *Virginia Beach*
Griffith, Kenneth Cornell, *Richmond*
Guss, John H, *Staunton*
Gwathmey, Owen, *Aylett*
Hammond, Billy A F, *Richmond*
Hartman, Carl William, *Norfolk*
Hoare, Raymond Robert, *Arlington*
Holland, William Elisha, *Richmond*
Hollingsworth, John H, *Roanoke*
Horgan, John A, *Newport News*
Howard, Robert L, *Locust Grove*
Hudson, Charles A, *Alexandria*
Hughes, David G, *Richmond*
Johns, Dearing W, *Charlottesville*
Johnson, Harry I Jr, *Roanoke*
Jones, Benjamin C Jr, *Alexandria*
Kaminsky, Brian L, *Richmond*
Keller, Andrew J, *Falls Church*
Kenerson, John G, *Virginia Beach*
Klevan, Thomas M D, *Norfolk*
Kontos, Hermes Apostolou, *Richmond*
Krickovic, Milan Piersol, *Richmond*
Laidlaw, James Carter, *Winchester*
Langdon, Daniel C, *Newport News*
Lee, St George Tucker Jr, *Newport News*
Lee, William I, *Harrisonburg*
Lee, Won Ro, *Alexandria*
Leet, Christopher J, *Catharpin*
Levitt, Robert H, *Richmond*
Lewis, Richard A, *Fredericksburg*
Lewis, Richard Gordon, *Richmond*
Lewis, William D Jr, *Martinsville*
Lipskind, Stuart C, *Manassas*
Lystash, John C, *Roanoke*
Magee, Patrick F A, *Springfield*
Maillis, Maxwell S, *Springfield*
Mandanis, John P, *Arlington*
Marder, Carey Miles, *Vienna*
Marshall, Joseph K Jr, *Arlington*
Martin, Randolph P, *Charlottesville*
Martirosian, Edward D, *Richmond*
Matthews, Robert George, *Annandale*
Mc Cormick, Hugh Bernard, *Newport News*
Mc Cue, Carolyn Moore, *Richmond*
Mc Grath, Francis J, *Arlington*
Mc Guire, Lockhart Bemiss, *Charlottesville*
Mc Laurin, Lambert P, *Newport News*
Miller, Gary Price, *Abingdon*
Moni, K N, *Virginia Beach*
Moon, Young Ho, *Alexandria*
Moore, Alfred Andrew D, *Norfolk*
Moore, Carl A, *Lynchburg*
Morgan, E A Jr, *Portsmouth*
Murray, Gary C, *Waynesboro*
Newton, Richard Milton, *Roanoke*
Nichols, Allen B, *Newport News*
Nolan, Stanton Peelle, *Charlottesville*
Nygaard, Thomas W, *Lynchburg*
Oelrich, William L, *Norfolk*
Olichney, Michael Joseph, *Fredericksburg*
Papas, Alexander J, *Woodbridge*
Parker, John Patrick, *Norfolk*
Patterson, John L Jr, *Richmond*
Phillips, Charles W, *Richmond*
Poblete, Pio Ferrer, *McLean*
Pollock, Dean M, *Vienna*
Porter, Reno Russell, *Richmond*
Powelson, Stephen W, *Richmond*
Pritchard, George Emmett, *Richmond*
Quinn, John Charles, *Winchester*
Rholl, Kenneth S, *Alexandria*
Roark, John W, *Alexandria*
Robbins, Clayton Asa, *Petersburg*
Robbins, Joseph A, *Norfolk*
Robertson, Elmer S, *Richmond*
Robertson, Robert J, *Virginia Beach*
Robinson, Frederick Daniel, *Midlothian*
Rosenfeld, Stephen P, *Alexandria*
Rude, Robert E, *Roanoke*
Rutherford, William Jr, *Salem*
Sackett, Charles H, *Lynchburg*
Santoian, Edward C, *Arlington*
Scott, Ernest Gerard, *Lynchburg*
Sheikh, Mazhar U, *Alexandria*
Sherber, Harvey Saul, *Annandale*
Shiner, Philip Thompson, *Roanoke*
Singh, B K, *Fairfax*
Sipes, James Norton, *Falls Church*
Smith, Ray Huey, *Richmond*
Starr, John Walter, *Roanoke*
St Clair, Jesse W III, *Virginia Beach*
Stine, Ronald A, *Norfolk*
Stone, William M, *Alexandria*
Talbot, Frank James, *Alexandria*
Taylor, Jack Borden, *Norfolk*
Tholpady, Sudama S, *Wise*
Thomas, Shelton W, *Richmond*
Thorpe, Alice V, *Richmond*
Torkelson, Leif Oscar, *Mt Crawford*
Tucker, Stanley Cole, *Richmond*
Tyler, Gilman Rackley, *Richmond*
Watson, John C, *Alexandria*
Weaver, Yvonne J, *Richmond*
Wheeler, Thomas E III, *Fredericksburg*
Williams, Conger, *Kilmarnock*
Wootton, Percy, *Richmond*
Zadrozny, John H, *Staunton*
Zeevi, Gary R, *Richmond*

Cardiovascular Surgery

Ayres, Stephen M, *Richmond*
Barefoot, Sherwood Washington, *Virginia Beach*
Barnhart, Glenn R, *Norfolk*
Clark, James Howard, *Roanoke*
Crisler, Crile Jr, *Norfolk*
Derkac, Wayne M, *Norfolk*
Ducey, Kevin Francis, *Roanoke*
Farr, Joseph G, *Manassas*
Frantz, Paul T, *Roanoke*
Fulcher, Thomas M, *Falls Church*
Gayle, Robert Gordon, *Norfolk*
Goldman, Michael H, *Arlington*
Gregory, Roger Thorpe, *Norfolk*
Grinnan, George L B, *Norfolk*
Holsinger, James Wilson Jr, *Richmond*
Horton, Jack Donald, *Annandale*
Hurwitz, Richard L, *Norfolk*
Joshi, Anilkumar Raghunath, *Norton*
Kaul, Sanjiv, *Charlottesville*
Kochicheril, Moni N, *Virginia Beach*
Landolt, Cleland C, *Annandale*
Lerman, Bruce B, *Charlottesville*
Levinson, Harold Jay, *Richmond*
Lim, Edmon Wang Ki, *Fairfax*
Mac Manus, Quentin, *Annandale*
Mroczek, William J, *Falls Church*
Nahormek, Patricia Alice, *Newport News*
Newton, Calvin M, *Richmond*
Nolan, John J, *Arlington*
O'Brien, John Terence, *Annandale*
Old, W L III, *Newport News*
Park, Crawford Dick, *Portsmouth*
Poliquin, James R, *Richmond*
Posner, Marc Philip, *Richmond*
Reynolds, Richard R, *Richmond*
Rodriguez-Ramos, Ernesto, *South Hill*
Sabri, Moustafa Nagui M, *Richmond*
Schareghi, Khosro, *Woodbridge*
Shukla, Padma Kant, *Reston*
Snyder, Stanley O Jr, *Norfolk*
Speir, Alan M, *Annandale*
Spotnitz, William D, *Charlottesville*
Stalker, Campbell Grieve, *Richmond*
Tayal, Krishan K, *Radford*
Thakkar, Muljibhai Jethabhai, *Grundy*
Tribble, Curtis G, *Charlottesville*
Vaughan, G Dennis III, *Winchester*
Wells, David C, *Roanoke*
Wolfgang, Timothy C, *Richmond*
Woolfolk, Donald Irwin, *Williamsburg*
Wrobel, Jerzy Waclaw, *McLean*
Zocco, J James, *Richmond*

Child Neurology

David, Ronald B, *Richmond*
Frank, L Matthew, *Norfolk*
Pellock, John Michael, *Richmond*
Sisk, Michael Anthony, *Roanoke*
Wilson, James T III, *Roanoke*

Child Psychiatry

Allen, Joseph J, *Portsmouth*
Anderson, Walter E, *Alexandria*
Baldemor, Anita B, *Danville*
Balzarett, Joseph Raymond, *Vienna*
Beshara, Dennis Lee, *Richmond*
Bhatia, Maya C, *Alexandria*
Bohlke, Glen Leroy, *Virginia Beach*
Briscoe, William Cole, *McLean*
Byron, Cheryl Ann, *Vienna*
Carter, Wesley Byrd, *Richmond*
Chapman, A Bradley, *Alexandria*
Crichigno, G A, *Midlothian*
Dalton, Fred Clinton, *Petersburg*
Derdeyn, Andre Philip, *Charlottesville*
Dietze, Claus J, *Falls Church*
Doenlen, Henry Alexander III, *Salem*
Dowling, Jean Marie, *Virginia Beach*
Elliott, Billie L Wright, *Richmond*
Enslin, Jessie Marsh, *Lynchburg*
Garner, Bennett W, *Newport News*
Glick, Howard Aaron, *Leesburg*
Gomez, Humberto, *Richmond*
Gondos, Gordon Morris, *Annandale*
Gormley, David Paul, *Falls Church*
Gray, William G, *Roanoke*
Halapin, Philip Thomas, *Charlottesville*
Haun, Eloise F Clymer, *Woodstock*
Hauser, Walter Arthur, *Petersburg*
Hlusko, Paul, *Radford*
Hoar, Barbara R, *Alexandria*
Imershein, Ruth Elizabeth, *McLean*
Jones, J Kipling, *Chesterfield*
Kaplan, Kenneth Lawrence, *McLean*
Kirchner, Frank H, *Virginia Beach*
Kolansky, Saul Kalman, *Alexandria*
Kowatch, Robert Anthony, *Richmond*
Licamele, William Louis, *McLean*
Lindemann, Lillian C, *Richmond*
Marcus, Spencer D, *Newport News*
Mc Curdy, Pamela Mary, *McLean*
Mc Murrer, James P Jr, *Vienna*
Michener, Frank Ervine, *Alexandria*
Palombi, Joseph John, *Fairfax*
Parmelee, Dean X, *Richmond*
Renfield, Marilyn Lewis, *Falls Church*
Repass, James C, *Virginia Beach*
Reynolds, Elizabeth M, *Lynchburg*
Roberto, Frank A, *Norfolk*
Salih, Hassan A, *Annandale*
Schlobohm, Josefina T, *Richmond*
Sellman, James E, *Richmond*
Snead, Ronald Wilson, *Richmond*
Sonenklar, Neil Allen, *Richmond*
Steckler, Eric Alan, *Mc Lean*
Strother, Arnold F, *Richmond*
Tapper, Franklin Bruce, *Virginia Beach*
Torres, Patricio, *Richmond*
Waring, Milton G, *Norfolk*
Wertheim, Raymond B, *Arlington*
Woloy, Eleanora Marie, *Virginia Beach*
Wooldridge, James W Jr, *Richmond*

Clinical Pathology

Ammann, Kathleen Mraz, *Vienna*
Bradley, Joy Jolliffe, *Richmond*
Briere, Russell Ovide, *Richmond*
Bruns, David E, *Charlottesville*
Clark, Pamela, *Richmond*
Dos Santos, Joao G III, *Richmond*
Fisher, Lyman McArthur, *Richmond*
Gailliot, Robert Vernon, *Marion*
Geltner, Jane Weinberg, *Alexandria*
Harrer, David S, *Falls Church*
Herold, David Allen, *Charlottesville*
Jessee, Wayne Phillip, *Staunton*
Milby, Willard Phaup III, *Richmond*
Monroe, Willys Moore, *Richmond*
Oble, Rosa Christiane, *Waynesboro*
Perez, Ana Maria, *Radford*
San Diego, Carmelita M, *Portsmouth*
Sprague, Robert Ingram, *Richmond*
Zientek, Gary Michael, *Charlottesville*

Clinical Pharmacology

Beaver, William Thomas, *Waterford*
Board, Anne J Woodrum, *Richmond*
Finch, Elizabeth Lathrop, *Alexandria*

Colon/Rectal Surgery

Bell, Leslie M, *Winchester*
Calvert, G Edward, *Lynchburg*
Colvin, Donald B, *McLean*
Dickson, William Henry, *McLean*
Gregory, James Stewart, *Richmond*
Hannan, Charles E, *Arlington*
Kovalcik, Paul J, *Portsmouth*
Moro, George Robert, *Virginia Beach*
Morrison, John G, *Richmond*
Onsanit, Tawachai, *Virginia Beach*
Palmintier, Jon S, *Richmond*
Ramirez, Renato Fajardo, *Portsmouth*
Smith, Crawford C, *Richmond*
Stewart, William Bruce, *Richmond*
Timmerman, William R, *Richmond*

Dermatology

Aaronson, Charles Martin, *Fairfax*
Albert, Moses Kadvanel, *Annandale*
Anderson, Charles William, *Norfolk*
Anderson, Woodland W Jr, *Newport News*
Andrews, James C, *Charlottesville*
Askew, Fletcher C Jr, *Charlottesville*
Baade, Wilhelm M, *Blacksburg*
Becker, Stanley Harold, *Richmond*
Berman, Harold John, *Alexandria*
Blackmore, John Robert, *Richmond*
Blakely, Lee Add, *Springfield*
Blanchard, Lawrence E III, *Richmond*
Blaylock, W Kenneth, *Richmond*
Booth, Jerry Clark, *Richmond*
Brady, John W Jr, *Manassas*
Braunstein Wilson, Barbara, *Charlottesville*
Broder, Robert I, *Alexandria*
Bronstein, Scott Wayne, *Reston*
Brownstein, Willis Edwin, *McLean*
Bruckner, Nancy V, *McLean*

Dermatology *(cont'd)*

Brust, Stuart William, *Lynchburg*
Buchanan, Charles Stuart, *Winchester*
Caravati, Charles M Jr, *Richmond*
Carter, Robert Lee, *McLean*
Cawley, Edward Philip, *Charlottesville*
Chandler, Harold Lee, *Norfolk*
Coker, William Luther Jr, *Hampton*
Comer, James Edward Jr, *Roanoke*
Costa, Jack Michael, *Fairfax*
Curcio, Edward P, *Falls Church*
De Angelis, Robert Neal, *Springfield*
Dent, Cynthia H, *Charlottesville*
Dumler, John Charles Jr, *Harrisonburg*
Dundon, Bruce Carroll, *Virginia Beach*
Evans, Eugene M Jr, *Danville*
Fang, Edith May-Wei, *Richmond*
Fitzgerald, Walter C, *Danville*
Fohl, Richard Bell, *Richmond*
Francis, Jamison Kendall, *Woodbridge*
Friedman, Asher A, *Norfolk*
Fuchs, Glenn H, *Fairfax*
Gibbs, W P, *Lynchburg*
Gibson, John E, *Alexandria*
Golomb, Herbert S, *Falls Church*
Gore, Herschel C, *Fairfax*
Gottlieb, Audrey Lynn, *Glen Allen*
Gottwald, William, *Richmond*
Greer, Kenneth Edward, *Charlottesville*
Gross, Gary P, *Salem*
Grossman, Debra Joan, *Charlottesville*
Gurney, Robert W, *Reston*
Harris, Herbert Witt Jr, *Blacksburg*
Henderson, Tabitha Anne, *Saltville*
Hickman, Janet G, *Lynchburg*
Horn, Martin Seth, *Fairfax*
Hudgins, Earl Maxwell, *Richmond*
Hwang, Richard John, *Ft Belvior*
Jordan, William P Jr, *Richmond*
Kabir, David Ilchi, *Alexandria*
Kaufman, John Pearse, *Roanoke*
Kaufman, Joseph H, *Alexandria*
Kazakis, Alexandra M, *Springfield*
Kelly, Leonard W Jr, *Richmond*
Kheir, Sonia Mikhail, *Vienna*
Kimbrough, Raymond D, *Richmond*
Kitces, Eileen C, *Richmond*
Knight, Yvonne, *Richmond*
Konerding, Hazle S, *Richmond*
Kravitz, Paul H, *Burke*
Krop, Thomas Monroe, *Virginia Beach*
Lampros, Jim Nicholas, *Roanoke*
Landes, Harold Brian, *Winchester*
Legum, Larry L, *Chesapeake*
Lesowitz, Sidney Allan, *Falls Church*
Mackel, Susan E, *Newport News*
Manley, Walter F, *Roanoke*
Manley, Walter F Jr, *Roanoke*
Manson, R Campbell, *Richmond*
Mc Call, Calvin O, *Winchester*
Mc Cloud, Deborah J, *Martinsville*
Mc Daniel, David Henry, *Virginia Beach*
Mc Mullan, Francis H, *Richmond*
Merritt, Carolyn C, *Petersburg*
Miot, Marie J, *Virginia Beach*
Mitchell, Russell Harry, *Leesburg*
Mora, Ricardo G, *Norfolk*
Moreland, Michael E, *Chesapeake*
Moshell, Alan N, *Burke*
Murray, Philip F, *Hampton*
Murrell, Thomas W Jr, *Richmond*
Musgrave, Joseph Walker, *Williamsburg*
Neal, Berryman Voss, *Newport News*
Nelson, Douglas L, *Newport News*
Netick, Joe, *Charles City*
Nims, Linda Park, *Vienna*
O'Neill, Thomas M, *Reston*
Oppenheim, Arnold Richard, *Virginia Beach*
Pariser, David Michael, *Norfolk*
Pariser, Harry, *Norfolk*
Pariser, Robert Jay, *Norfolk*
Parsons, Jerome Michael, *Portsmouth*
Patterson, James W, *Richmond*
Patton, Larry W, *Roanoke*
Pauly, Charles Roman, *Waynesboro*
Payne, Charles F Jr, *Portsmouth*
Pepple, Allen W, *Richmond*
Quarles, Frederick N, *Hampton*
Rand, Seymour, *Arlington*
Reams, B Thomas, *Midlothian*
Richardson, Donald R, *Charlottesville*
Richardson, Douglas Scott, *Leesburg*
Rivera, Michelle Antonia, *Arlington*
Robarge, I James, *Alexandria*
Robinson, James F, *Richmond*
Rotchford, James Patrick, *Arlington*
Rubin, Max Bernard, *McLean*
Sacks, Henry G, *Fredericksburg*
Sampson, Alan L, *Alexandria*
Saunders, Milton A Jr, *Virginia Beach*
Sawada, Kathleen Yumi, *Richmond*
Sawchuk, William Samuel, *Falls Church*
Schuldenfrei, Jeffrey Alan, *Springfield*
Schwartz, Arnold Jay, *Virginia Beach*
Schwartz, Julius L, *Petersburg*
Schwartz, Leslie, *Fredericksburg*
Scoggins, Robert Bruce, *Richmond*
Selden, Samuel Thwing, *Chesapeake*
Sharpe, Larry Odell, *Norfolk*
Sheap, Christopher Newkirk, *Harrisonburg*
Shields, William J, *Newport News*
Shrum, John Richard, *Charlottesville*
Silverman, Robert Alan, *Annandale*
Sowers, William F, *Staunton*
Stark, Randolph Wilkinson, *Manassas*
Stevens, Michael Peter, *Fredericksburg*
Stevens, Patricia E P, *Fredericksburg*
Straka, Bonnie Foster, *Earlysville*
Swan, Harvey F, *Alexandria*
Szulecki, Judith Marie, *Martinsville*
Thornton, Nancy H, *Richmond*
Treherne, Katherine A, *Norfolk*
Trice, Ernest Randolph, *Richmond*
Vaughan, Brenda E, *Richmond*
Watkins, William T Jr, *Yorktown*
Weary, Peyton Edwin, *Charlottesville*
Weber, Charles B, *Arlington*
Wessels, Mia Ruth, *Marion*
Whitmore, Charles W, *Lynchburg*
Whitmore, Mary Claire, *Lynchburg*
Wilhite, Philip A Jr, *Goshen*
Wood, Bobby T, *Newport News*
Wyles, Ronald Joseph, *Virginia Beach*
Young, Estelle Irene, *Petersburg*

Diabetes

Meloni, Charles Robert, *Alexandria*
Owen, John Atkinson Jr, *Charlottesville*

Diagnostic Radiology

Allen, Harry Alexander III, *Virginia Beach*
Armstrong, Peter Jr, *Charlottesville*
Armstrong, Robert H Jr, *Onancock*
Backer, Joseph Anthony, *McLean*
Beauchamp, Ray Alonzo, *Richmond*
Behl, Joseph W Jr, *Harrisonburg*
Bittner, Gloria Mary, *Charlottesville*
Blair, Deborah N, *Alexandria*
Bosworth, James Elam, *Virginia Beach*
Bowen, David Rory, *Hampton*
Brewer, William Henry, *Richmond*
Bridges, David Marvin, *Norfolk*
Brock, Karen Reno, *Galax*
Brookeman, Valerie Ann Bain, *Charlottesville*
Burke, Timothy S, *Richmond*
Cail, Wayne Stephen, *Charlottesville*
Caldwell, John Leo, *Falls Church*
Caldwell, Paul Charles, *Harrisonburg*
Chiavarini, Robert Louis, *Virginia Beach*
Childs, Theron Baker, *White Stone*
Christian, George Henry, *Virginia Beach*
Cigtay, Attila Sakir, *Alexandria*
Ciric, Andrew M, *Virginia Beach*
Clarke, Douglas V, *Warrenton*
Cocke, John Alexander, *Virginia Beach*
Cockrell, Charles H, *Petersburg*
Cook, Irving Kenneth, *Waynesboro*
Craddock, William E, *Charlottesville*
Creekmore, Robert Sherman, *Roanoke*
Crocker, Norman Lloyd, *Richmond*
Cuthbert, Nathaniel West, *Salem*
Daimler, John Charles, *Newport News*
Davies, Linda High, *Culpeper*
De La Vega, Raul Stephen III, *Danville*
De Le Vega, Raul S, *Danville*
Devanath, Nripendra C, *Suffolk*
Disantis, David Joseph, *Virginia Beach*
Doerr, Janet Allison, *Staunton*
Druckman, Daniel Lucas, *Arlington*
Dunn, Neil Fraser Sinclair, *Yorktown*
Eisenberg, Stuart J, *Richmond*
Enright, Michael Joseph, *Charlottesville*
Epling, Susan Barrow, *Abingdon*
Fish, George Dennis, *Fredericksburg*
Fitzer, Peter Malcolm, *Newport News*
Fleming, Martin P, *Berryville*
Fogel, William Martin, *Richmond*
Fox, Parham R, *Lynchburg*
Frey, Allen Arthur, *Manakin Sabot*
Friedman, Michael Herbert, *Alexandria*
Girevendulis, Alexander K, *Richmond*
Goldschmidt, Robert A, *Richmond*
Goodman, Harold, *Richmond*
Gopalan, Srikumar, *Wise*
Green, Ira Joel, *Alexandria*
Grella, Benjamin Jr, *South Hill*
Haines, Garland Thomas, *Wise*
Halden, William J Jr, *Reston*
Hartenberg, Michael A, *Richmond*
Head, Gordon Lawrence, *Oakton*

Diagnostic Radiology *(cont'd)*

Hecht-Leavitt, Charles M, *Norfolk*
Hersh, Stephen Robert, *Springfield*
Hewitt, Michael J, *Fredericksburg*
Hightower, Howard E, *Suffolk*
Hindle, William Vincent Jr, *Alexandria*
Hipol, Manuel A, *Virginia Beach*
Houser, Aubrey A Jr, *Richmond*
Huggins, James Boyd, *Staunton*
Hughes, Felix A, *Virginia Beach*
Hunter, James Gordon, *Lynchburg*
Hutton, Charles Frederick, *Richmond*
Johnson, Allen C, *Petersburg*
Kahn, Ralph Y, *Rocky Mount*
Katz, Michael E, *Norfolk*
Kauffman, William M, *Alexandria*
Keats, Theodore Eliot, *Charlottesville*
Kerns, Scott Robert, *Charlottesville*
King, Ronald Lester, *Virginia Beach*
Kiser, Pamela Elaine, *Richmond*
Kishore, P R S, *Richmond*
Knopf, Reuben De Loach, *Roanoke*
Knull, Alan Franklin, *Woodstock*
Konerding, Karsten F, *Richmond*
Kubota, Richard Tadashi, *Richmond*
Laine, Fred Julius, *Richmond*
Lampton, Lee D, *Suffolk*
Larkin, Lawrence D, *Lynchburg*
Le, Cong Van, *Fairfax*
Lebolt, Scot Alan, *Burke*
Levine, Jay M, *Richmond*
Lewis, Van L, *Roanoke*
Lindstedt, Jan Gustaf, *Vienna*
Lippert, John Charles, *Danville*
Lowdon, Jack, *Virginia Beach*
Martin, George W Jr, *Midlothian*
Martinelli, Maurice Ivan, *Virginia Beach*
Mc Kenzie, Susan E, *Virginia Beach*
Mc Knight, G Dean, *Alexandria*
Mc Wey, Russell Eugene, *Herndon*
Medsker, Thomas T, *Fredericksburg*
Miller, Stephen L, *Manassas*
Morgan, Carlisle L Jr, *Richmond*
Morris, J Leon, *Charlottesville*
Moss, Morton Lionel, *Burke*
Mullens, John Richard III, *Abingdon*
Mullet, James Goddard, *Richmond*
Myles, John Turpin, *Gloucester*
Nadel, Lynn, *Richmond*
Nathe, James Edward, *Waynesboro*
Neal, M Pinson Jr, *Richmond*
Neil, Elmer E, *Richmond*
Oberheu, Victor, *Danville*
O'Connell, Leo Patrick, *Newport News*
Oliff, George Anthony, *Richmond*
Olson, William B, *Williamsburg*
Paling, Michael Royse, *Charlottesville*
Parker, Joel F, *Mechanicsville*
Phillips, Clifford Douglas, *Earlysville*
Pohl, Christoph, *Richmond*
Pope, Thomas L Jr, *Charlottesville*
Proctor, William Franklin, *Richmond*
Proto, Anthony V, *Richmond*
Pumroy, Keith Spence, *Chesapeake*
Ray, Hallie Anne, *King George*
Redlin, William Lloyd, *Falls Church*
Redmond, Larry Hollis, *Lynchburg*
Register, Thomas Eugene Jr, *Alexandria*
Reid, Steven Hunter, *Richmond*
Restivo, Marion C, *Springfield*
Reznikov, Paul David, *Glen Allen*
Rhodes, Hebert Paul Jr, *Bedford*
Riddervold, Hans Olav, *Charlottesville*
Rogers, William E, *Waynesboro*
Rollins, Dixon Michael, *Suffolk*
Scheer, Cherie E, *Richmond*
Scott, David William III, *Fredericksburg*
Seale, Daniel Logan, *Charlottesville*
Shaffer, Hubert Adams Jr, *Charlottesville*
Shah, Krishnajivan Chhabildas, *Grundy*
Sison, Antonio Posadas, *Richmond*
Slutsky, Vera S, *Richmond*
Smith, Lamar H, *Virginia Beach*
Smithson, Lori Verdol, *Richmond*
South, James Gregory, *Richmond*
Southworth, Lawrence E, *Fredericksburg*
Spinos, Efstathios, *Midlothian*
Straughan, Joseph Marion, *Wise*
Sullivan, Harvey E III, *Marion*
Tegtmeyer, Charles John, *Charlottesville*
Thomas, William Odell, *Roanoke*
Tipler, Bradley M, *Staunton*
Turner, Mary Ann, *Richmond*
Vinson, Alfred Mitchell, *Norfolk*
Wallace, Karl Kenneth Jr, *Virginia Beach*
Weaver, David Lee, *Norfolk*
Weaver, John A, *Richmond*
Weiner, Paul Lee, *McLean*
Weiss, Michael Aron, *Burke*
Weller, William Franklin, *Roanoke*
Wheeler, William F, *Norfolk*
Whitbeck, John Volkert, *Virginia Beach*
Wiebe-King, Steven Marshall, *Richmond*
Wilcox, Clyde W Jr, *Virginia Beach*
Wiley, Roger P, *Roanoke*
Willis, Calvin Johnson, *Halifax*
Woodlief, Ray Marshall, *Richmond*
Woolard, Douglas W, *Martinsville*
Yaeger, John Julius, *White Sulphur Springs*
Yoon, Insook, *Vienna*
Zazzaro, Patrick Francis, *Manassas*
Zimmerman, Harold Baer, *Falls Church*

Emergency Medicine

Abhyankar, Ramola Sharad, *Herndon*
Aladj, Lawrence J, *Norfolk*
Albanese, Robert, *Martinsville*
Albert, Martin P, *Charlottesville*
Armstrong, Carl William, *Richmond*
Ascue, Joseph Thomas, *Bluefield*
Bailey, Thomas Daniel, *Lynchburg*
Barker, William J, *Fairfax*
Barsanti, Thomas G, *Falls Church*
Bass, Stuart Kenneth, *Richmond*
Berdeen, Thomas Neal Jr, *Roanoke*
Bertolini, John Carter, *Arlington*
Bhandary, Sharada Ram, *Franklin*
Blay, Andrew Brian, *Harrisonburg*
Boyd, John O Jr, *Goodview*
Boyles, James Edward, *Front Royal*
Bragg, Phyllis Anne, *Centreville*
Broaddus, Reuben H Jr, *Richmond*
Brooks, Jonathan B, *Burke*
Brown, Ronald Bayard, *Virginia Beach*
Bruckner, Jana Terezie, *Virginia Beach*
Bruns, Paul Donald Jr, *Herndon*
Caggiano, Gian Battista A, *Winchester*
Calhoun, Philo Clark, *Charlottesville*
Campbell, Walter Arthur, *Richmond*
Carleo, James Onofrio, *Virginia Beach*
Case, Randall Bryan, *Springfield*
Castern, Louis J, *Roanoke*
Cetrone, Anthony C, *Portsmouth*
Chapin, Charles Thomas, *Arlington*
Clark, David A, *Midlothian*
Cockerham, Glenn Cooper, *Alexandria*
Cole, Charles Edward, *Virginia Beach*
Colina, Jose Fajardo Jr, *Tappahannock*
Colpitts, Terence James, *Blacksburg*
Colson, George Bernard, *Vienna*
Combs, Allen Evans, *Yorktown*
Constant, Tony Jr, *Richmond*
Coqueran, Adrienne Louise, *Portsmouth*
Cordero, Jimmy P, *Clifton*
Corse, Kenneth J II, *Emory*
Craven, Richard Allen, *Virginia Beach*
Davis, Mark Philip, *Reston*
Dellinger, James L, *Dugspur*
Del Pilar, Jaime V, *Manassas*
Devine, Charles Joseph III, *Virginia Beach*
Downs, Edward Jay, *Virginia Beach*
Downs, Peter Ellsworth, *Virginia Beach*
Du Buy, Jean B, *Hampton*
Du Buy, Jean Bernard, *Hampton*
Dunford, Joseph L, *Centerville*
Dyer, Charles E, *Fairfax Station*
Emmel, Alfred Cortland, *Grafton*
Espinosa, Myrna Mendiola, *Virginia Beach*
Fensterer, Philip H Jr, *Halifax*
Flynn, Thomas Francis, *Norfolk*
Garrett, James Ellis, *Virginia Beach*
Garvin, John M, *Roanoke*
Generelly, Peter Roger, *Palmyra*
Genio, Dominador Diokno Jr, *Tazewell*
Ghezzi, Keith Thomas, *McLean*
Giangola, John, *Winchester*
Goeden, Michael Joe, *Fredericksburg*
Goeden, Nancy Jean, *Fredericksburg*
Gonzalez, Ramon Leopoldo, *Burke*
Gorman, Jerome Davis, *Richmond*
Grimes, Stephen Arthur, *Newport News*
Gruber, Frank W, *Chesapeake*
Gubb, Geoffrey W, *Onancock*
Guirguis, Habib Habib, *Bon Air*
Hall, Melinda S, *Falls Church*
Hammersberg, Jon R, *Middlebrook*
Harris, Mark Morrow, *Charlottesville*
Hawkins, John Woodruff, *Midlothian*
Heard, Sam Bryan, *Fredericksburg*
Heatwole, Stanley E, *Staunton*
Helfer, Sidney P, *Norfolk*
Hemsley, Hugh H Jr, *Midlothian*
Hodgson, John McBarron, *Midlothian*
Holden, Todd Smith, *Stephens City*
Holland, Marie Tulou, *Norfolk*
Huff, John Stephen, *Virginia Beach*
Humphries, William H Jr, *Roanoke*
Hunter, William Mills, *Seaford*
Hurley, Moira R, *Springfield*
Hyman, Lawrence Craig, *Hampton*

Emergency Medicine *(cont'd)*

Isenberg-Dallaire, Louise Alexander, *Virginia Beach*
Iskander, Azmy A, *Fairfax*
Jackson, Marie Christine, *Danville*
Johnson, Walter C, *McLean*
Jonas, Wayne Boice, *Alexandria*
Jones, Albert Mitchell, *Midlothian*
Jones, Benjamin Newman, *Salem*
Jones, Ronald Homer, *Virginia Beach*
Jones, Wendy S, *Fairfax*
Jose, Reynaldo Duiguan, *Pocahontas*
Kardon, Eric Mitchell, *Norfolk*
Karp, Nelson Marc, *Virginia Beach*
Keary, Frank Vincent, *Annandale*
Kelleher, Alfred B, *Midlothian*
Kelly, Kathleen Patricia, *Alexandria*
Kidwell, John Aaron, *Harrisonburg*
Konigsberg, James Louis, *Fairfax*
Lander, David Henry, *Floyd*
Lanier, Andrew Stephens, *Floyd*
Larsen, Kenneth T Jr, *Alexandria*
Leary, John Michael, *Roanoke*
Leavy, Philip G Jr, *Norfolk*
Lee, Jong Kook, *McLean*
Lee, Sun Geun, *South Boston*
Leidelmeyer, Reinald, *Fairfax*
Lenett, Stephen David, *Richmond*
Lewis, Donald Wray, *Norfolk*
Lewis, Karl Chester, *Tazewell*
Livingston, David Barker, *Abingdon*
Lorenz, Martin Fred, *Virginia Beach*
Lothes, Christopher M, *Roanoke*
Loughridge, Chalmers A, *Alexandria*
Ludlow, Kimberley Ann, *Radford*
Mac Pherson-Smith, M L C, *Virginia Beach*
Maier, Susan Leah, *Alexandria*
Mann, Michael Scott, *Virginia Beach*
Manrique, Richard Leon, *Portsmouth*
Marcus, Rebecca B, *Fredericksburg*
Marven, Lee Jonathan, *Virginia Beach*
Massie, James D, *Lynchburg*
Maxfield, John Fowler, *Alexandria*
Mc Coig, Forrest D, *Hampton*
Mc Dade, John Patrick, *Alexandria*
Mc Dill, Phillip Wade, *Clifton Forge*
Mc Guffin, Robert O Jr, *Roanoke*
Mc Neill, Donald Hanson, *Front Royal*
Mendez, Hedley N III, *Poquoson*
Midgley, Peter Mckay, *Fairfax Station*
Mier, Jose Ferreras Jr, *Danville*
Milzman, David Paul, *Virginia Beach*
Miranda, Prospero Lumgui, *Virginia Beach*
Molina, Galileo T, *Richlands*
Morres, Clark Alton, *Fairfax*
Moseley, James Alan, *Winchester*
Mueller, John B, *Arlington*
Mulvaney, Richard Joseph, *McLean*
Nichols, Keith Cameron, *Martinsville*
Nicholson, Bruce David, *Charlottesville*
Obrams, Gunta I, *Alexandria*
Packer, Gerald A, *Williamsburg*
Palace, William George, *Vienna*
Parmelee, Warren Earl, *Falmouth*
Parrent, Phyllis Ann, *Axton*
Parrish, Thomas G, *Roanoke*
Pascual, Vianmar G, *Virginia Beach*
Pasicov, Benjamin, *McLean*
Paulson, Debra Jo, *Stuarts Draft*
Pennings, Simon P, *Abingdon*
Petticrew, Jeffrey B, *Virginia Beach*
Pierce, Mark Rainer, *Richmond*
Piland, Kimberly Morgan, *Norfolk*
Ponce, Juan F, *Virginia Beach*
Powers, David W, *Winchester*
Price, Richard A, *Alexandria*
Pryor, Donald Charles, *Virginia Beach*
Rao, Jaikar S, *Richmond*
Rapp, Michael T, *McLean*
Ray, Gaylord White, *Gloucester*
Read, Mallory Joseph Jr, *Norfolk*
Realica, Buenaventura S, *Richlands*
Riddel, Clifford T Jr, *Bridgewater*
Rodney, Kurt G, *Arlington*
Ryan, Thomas J, *Oakton*
Saetrum, Brent Bjorn, *Manassas*
Samaha, Richard George, *Williamsburg*
Scherer, Edward U, *Richmond*
Schmidt, James L, *Appalachia*
Scholten, James Robert, *Norfolk*
Scranage, Clarence Jr, *King George*
Selove, Peter T, *Martinsville*
Shaffer, Kathleen Laurell, *Norfolk*
Shipman, Charles Edward, *Virginia Beach*
Shuster, Michael Joel, *McLean*
Slepin, Mark Jeffrey, *Virginia Beach*
Spurgeon, Paul Stanley, *Alexandria*
Stephens, Wesley G, *Troutville*
Stewart, Joan Rae, *Virginia Beach*
Stinger, Robert Bruce, *Alexandria*
Streicker, William F, *Richmond*
Surrusco, Richard M, *Roanoke*
Talbott, William G, *Charlottesville*
Tek, Deniz Server, *Virginia Beach*
Tims, Roger Dean, *Salem*
Tompkins, Lornel Garlita, *Midlothian*
Turnbaugh, Lois Wilson, *Suffolk*
Vaidy, Mohan T, *Richmond*
Valera-Franco, Edna, *Alexandria*
Vargas, Matthias Jonathan, *Norfolk*
Wahlgren, Christopher John, *Richmond*
Ward, Charles Harper, *Warsaw*
Watkins, Jimmie Parks, *Chesterfield*
Watson, Francis E, *Chesapeake*
Weaver, William J Jr, *Locust Grove*
Weeke, Paul Craig, *Halifax*
Weiland, Douglas John, *Roanoke*
Weiss, Brian Douglas, *Newport News*
Wertz, Charity Marcy, *Chesterfield*
Wilner, Steven Ross, *Reston*
Wolford, Keith Harlow, *Grafton*
Yeiser, Frank M Jr, *Norfolk*
Yerkovich, Stephen A, *Vienna*
Yoon, Sung Won, *Fairfax*
Zurlo, Joseph A, *Fairfax Station*

Endocrinology

Atkinson, Richard L Jr, *Hampton*
Barr, Arnold B, *Norfolk*
Bivens, Carl Hill Jr, *Roanoke*
Carey, Robert Munson, *Charlottesville*
Coddington, Charles Campbell, *Virginia Beach*
Dunn, John T, *Charlottesville*
Habib, Tahira, *Alexandria*
Harrison, H Courtenay, *Virginia Beach*
Kirkland, Richard Horace, *Richmond*
Mountcastle, Robert Boxley Jr, *Roanoke*
Newman, Eugene Michael, *Richmond*
Siragy, Helmy Mohamed, *Charlottesville*
Taylor, Andrea M, *Charlottesville*
Temple, T Eugene Jr, *Newport News*
Thorner, Michael O, *Charlottesville*
Townsend, Irene, *Glasgow*

Family Practice

Aaron, Maureen Margaret, *Martinsville*
Abbey, Linda, *Midlothian*
Abbot, David Munro, *Oakton*
Adams, Douglas H, *Roanoke*
Adams, Douglas Harvey, *Roanoke*
Adams, Samuel Webster, *Martinsville*
Adams-Hudson, Brenda L, *Hampton*
Adiele, Nkwachukwu Moses, *Richmond*
Ajgaonkar, Ashok Dinkar, *Charlottesville*
Albers, Gregg Richard, *Lynchburg*
Alberts, Wayne William, *McLean*
Amick, Robert L Jr, *Roanoke*
Amonette, Mark Steven, *Newport News*
Amos, J Francis, *Rocky Mount*
Anderson, Glenn, *Burke*
Anderson, J Powell, *Waynesboro*
Anderson, James C, *Midlothian*
Anderson, John Ryan, *Fredericksburg*
Anderson, Peter Bland, *Newport News*
Andrews, Clarke Butler, *Fincastle*
Anthony, Ervin Edel, *Heathsville*
Archibald, Rowena Louise, *Hampton*
Arey, Donald Lurton, *Danville*
Arey, Jo Ann, *Galax*
Arey, Vaughn R, *Galax*
Armstrong, Charles Lindbergh, *Alexandria*
Asercion, Dorcas Castillo, *Virginia Beach*
Ashby, Richard Bruce, *Bailey's Crossroads*
Ashworth, Charles Vincent Jr, *Lynchburg*
Ashworth, Joel T Jr, *Richmond*
Austin, Gregory Eric, *Hampton*
Avery, Janet, *Sterling*
Ayers, Richard Blair, *Virginia Beach*
Badillo, Leslie E, *Christiansburg*
Baez-Page, Socorrito Luise Baez, *Alexandria*
Bailey, Dwight L, *Lebanon*
Bailey, Paul Allen, *Portsmouth*
Bain, Francis Nott, *Goochland*
Ball, John James III, *Newport News*
Ball, William Flinn, *Roanoke*
Banzon, Amando L Jr, *Springfield*
Barham, Edward Adolphus, *Portsmouth*
Barker, Gerald Allan, *Lebanon*
Barnes, John G, *Midlothian*
Barnett, B Lewis Jr, *Charlottesville*
Barr, Lisa Binder, *Norfolk*
Barr, Mark Cameron, *Richmond*
Barton, James Edwin, *Williamsburg*
Barton, Sam, *Midlothian*
Barton, Walter S, *Wytheville*
Bartone, Mary Williamson, *Fairfax*
Bass, Robert Redwood, *Suffolk*
Bates, Jesse J, *South Boston*
Battle, Donald C, *Alexandria*
Baugh, Emerson D Jr, *Kenbridge*

Family Practice *(cont'd)*

Baum, Joseph James, *Laurel Fork*
Baxter, Robert Francis, *Grundy*
Beahm, Linda Sue, *Moneta*
Beavers, Aaron L Jr, *Roanoke*
Bednar, Stephen Joseph, *Lorton*
Beirne, Edward B, *Richmond*
Belote, Larry Pierce, *Purcellville*
Belote, Robert Keith, *Leesburg*
Belvin, David G, *Newport News*
Benavente, Marissa June, *Williamsburg*
Bencze, Robert F, *Leesburg*
Bendall, Richard A Jr, *Madison Heights*
Benito, Ruben T, *Stafford*
Bennett, Scott L, *Stafford*
Beres, Chester John, *Roanoke*
Berger, Alexander, *Portsmouth*
Berger, I Robert, *Radford*
Bertholf, Max Erwin, *Daleville*
Bethea, Charles Darnell, *Martinsville*
Bethel, Sonya Nadine, *Vienna*
Beverly, Walter B, *Lynchburg*
Bickel, Rudolf G, *Alexandria*
Bidwell, Glenn Porter Jr, *Franklin*
Bikowski, Richard Michael, *Chesapeake*
Binhammer, Harold E, *Midlothian*
Binnings, Clement Burke Jr, *Salem*
Birch, James Theodore Jr, *Chesapeake*
Bisgrove, Michael E, *Buchanan*
Bishop, Frank T, *Norfolk*
Black, Christopher Philip, *Fort Belvoir*
Black, Maxwell Frank Jr, *Warrenton*
Blake, Thomas D, *Richmond*
Bland, David Leonardus Jr, *Hampton*
Bley, Donald E, *Fredericksburg*
Blowe, Vanessa Arnethia, *Newport News*
Bluestein, Daniel Allen, *Norfolk*
Bono, Kathryn Luth, *Moneta*
Booker, J Motley, *Lottsburg*
Booker, James Judson III, *Wytheville*
Bowers, Leo Clayton, *Hampton*
Bowles, Richard Boxley Jr, *Centreville*
Bowman, Robert R Jr, *Stuart*
Boyce, E Lawrence Jr, *Bon Air*
Boyce, Franklin D Jr, *Colonial Heights*
Boyer, Debra, *Hampton*
Boyko, Michael John, *Broad Run*
Bradd, Floyd III, *Front Royal*
Bradshaw, Donald Matthew, *Springfield*
Bradshaw, Douglas M, *Harrisonburg*
Bragg, Arthur Dane, *Richmond*
Brammer, William Milton, *Bassett*
Branson, Donald Gene, *Lynchburg*
Brantley, Aurelius Walter, *Franklin*
Braza, Mary Elizabeth, *Vienna*
Breeden, Louis M, *Richmond*
Brewer, James Lloberas III, *Abingdon*
Brillhart, David M, *Abingdon*
Brittman, Stanley L, *Portsmouth*
Brna, Theodore George Jr, *Springfield*
Brock, Jay David, *Fredericksburg*
Brothers, Richard M, *Shenandoah*
Brown, Benjamin Timothy Brian, *Schuyler*
Brown, David Wayne, *Charlottesville*
Brown, Jennifer Blythe, *Richmond*
Brown, Joseph D III, *Williamsburg*
Brown, Leon J Jr, *Richmond*
Brown, Paul Garland, *Marion*
Brown, Raymond Sidney, *Gloucester*
Brown, William David, *Amherst*
Brubaker, Herman W, *Roanoke*
Brugh, Victor M II, *Richmond*
Bryant, John P, *Yorktown*
Bryce, William Fielding, *Bon Air*
Buchinsky, Vincent J, *Manassas*
Buckman, Paul Stewart, *Nathalie*
Bullard, George Minson Jr, *Tabb*
Bullock, Richard Edward, *Blacksburg*
Bumgardner, Jack H Jr, *Rocky Mount*
Burns, Dennis Edward, *Lynchburg*
Burroughs, Susan Hobbs, *Vienna*
Burton, Gary Wayne, *Herndon*
Bushey, Sarah Margaret, *Newport News*
Bustin, Frederick Bernard, *Stafford*
Buston, Jameson George II, *Richmond*
Buttery, C M G, *Midlothian*
Byer, Barry, *Falls Church*
Byrne, Robert Francis, *Virginia Beach*
Caldwell, Mary McFaden, *Richmond*
Calihan, Martha S, *Fairfax*
Camacho, Peligny L, *Virginia Beach*
Cametas, John Gus, *Richmond*
Campbell, Bruce Donald Jr, *Free Union*
Carmichael, Elizabeth B, *Vinton*
Carpenter, John M, *Richmond*
Carr, Robert Joseph, *Springfield*
Carroll, Frank A Jr, *Alexandria*
Carter, Elizabeth Wagner, *Vienna*
Carter, Francis C, *Altavista*
Carter, Hill Jr, *Ashland*
Carter, William H Jr, *Fairfax*
Cashion, Donald T, *Virginia Beach*
Cassidy, R L, *Norfolk*
Castaneda, Alberto J, *Virginia Beach*
Castillo, Probo H, *Richlands*
Caughron, Samuel C, *Charlottesville*
Caulkins, Michael Kennedy, *Lynchburg*
Caulkins, Pamela Marston, *Lynchburg*
Cave, William B, *Madison*
Cavros, George N, *Norfolk*
Cay, Emin Seref, *Falls Church*
Cella, Caroline Parker, *Richmond*
Chakrabortty, Saghana Baran, *Virginia Beach*
Chamberlain, Charles William, *Waverly*
Chaplin, Robert Rogers Jr, *Richmond*
Chapman, Val Loren, *Oakton*
Charlton, James Perry, *Virginia Beach*
Charlton, William J, *Virginia Beach*
Chase, Sandra Mae, *Fairfax*
Chefetz, Richard Alan, *Madison*
Chen, Cheng-Nan, *Alexandria*
Chiles, Morton P III, *Culpeper*
Chin, Dewey Wey, *Clifton*
Chisholm, Louis Randolph, *Midlothian*
Choi, Chai Chang, *Alexandria*
Christiano, Peter John, *Fairfax*
Christianson, Charles Edward, *Arlington*
Chung, Chung Ung, *Portsmouth*
Ciccone, Alvin Jacob, *Norfolk*
Clapsaddle, Gene Edward, *Moneta*
Clark, Craig Charles, *Fairfax*
Clarke, Mark Gregory, *Cape Charles*
Claustro, Ludgerio Z, *Cedar Bluff*
Clements, Boyd M, *Gloucester*
Cloninger, Kenneth Kyle, *South Boston*
Clothier, W J Kilburn Jr, *Ashland*
Coates, Michael L, *Charlottesville*
Cobaugh, Donn S, *Chester*
Cockrell, Wiley Thurman Jr, *Roanoke*
Coffey, E L, *Buchanan*
Cohen, Nourollah N, *Hampton*
Cole, James W III, *Midlothian*
Cole, Katherine Joyce, *Fairfax*
Cole, Richard Claude, *Stuart*
Cole, Richard Clinton, *Poquoson*
Coleman, George C, *Newport News*
Coll-Cabrera, Jose D, *Richmond*
Colletti, Nicholas George, *Woodbridge*
Comunale, R A, *McLean*
Conyers, Richard Mack, *Moseley*
Cooper, Patricia A, *Norfolk*
Cope, Gerry A, *Quantico*
Coulter, Steven Thomas, *Annandale*
Cover, Jesse R, *Fairfax*
Cowley, Richard, *Portsmouth*
Cox, David Baxter, *Gordonsville*
Craggs, Thomas F III, *Richmond*
Cranton, Elmer Mitchell, *Troutdale*
Craven, Bickley, *Pennington Gap*
Crawford, David J, *Waynesboro*
Creef, James W, *Chesapeake*
Crick, Jane Alice, *Newport News*
Crimm, Carl Eugene, *Annandale*
Crossen, David Keith, *Richmond*
Crossen, Richard William, *Richmond*
Croteau, Louis John, *Virginia Beach*
Crow, Harold E, *Lynchburg*
Crow, William Cecil Jr, *Fincastle*
Crowder, Charles H Jr, *South Hill*
Crowley, Anthony Edward, *Leesburg*
Crum, Frederick C, *Chesapeake*
Cui, Marie P, *Hampton*
Cummings, William Steven, *Williamsburg*
Cundiff, Maria Reeves, *Norfolk*
Cunningham, Michael John, *Buena Vista*
Cutter, Douglas Nathan, *Richmond*
Cypress, Stanley D, *Newport News*
Dageforde, James R, *Richmond*
Dallas, Olympia Panagiotis, *Springfield*
Dandridge, William R Jr, *Charlottesville*
Daniel, Jerome M, *Richmond*
Daniel, John G, *Reedville*
Danish, Louis Jack, *Richmond*
Darden, James Edgel, *Chesapeake*
Daugherty, John F, *Roanoke*
Davis, Russell Lewis Jr, *Radford*
Davy, Mark F, *Richmond*
Deaton, Richard Thomas, *Portsmouth*
Deboe, James Henry Jr, *Hillsville*
Deci, David Michael, *Strasburg*
Dedwylder, Rosier D II, *Dahlgren*
Degray, Stephen Alan, *Bluefield*
Del Sordo, Andrew A, *Richmond*
Demotts, Gregory L, *Nickelsville*
Denius, Larry Richard, *Hot Springs*
Derosa, Gary A, *Manassas*
Devereaux, Robert F, *Pearisburg*
Devlin, James Timothy, *Virginia Beach*
Devous, Arnold Scott, *Weber City*
Dhanvada, Padmavati Velala, *Newport News*
Diaz, Fernando Gregorio, *Gloucester Point*
Diaz, Oscar, *Norfolk*

Family Practice *(cont'd)*

Dickinson, Ella M, *Roanoke*
Dickson, Albert M Jr, *Virginia Beach*
Digerolamo, Albert, *Alexandria*
Dogrul, Suleyman S, *Hampton*
Doherty, Ernest Falkenburg, *Grafton*
Donelson, Martin Jr, *Danville*
Donovan, James Francis, *Clarksville*
Donovan, Mary Burleson, *Burkeville*
Duani, David Simon, *Stanardsville*
Dudley, James R, *Gloucester*
Duffer, Rufus Randolph, *Altavista*
Duncan, David Arend, *Powhatan*
Dunker, Robert Frey, *Virginia Beach*
Dyer, Cinda Robin, *Alexandria*
Eakin, Stephen Wayne, *West Point*
Eddins, William George, *Salem*
Eddy, Janet Mary, *Poguoson*
Edinger, Gregory John, *Virginia Beach*
Edmunds, Keith Castleton, *Salem*
Edwards, James T Jr, *Newport News*
Edwards, Preston H, *Salem*
Eisenstein, Steven Joseph, *Newport News*
Eissler, Corbin G, *Springfield*
Elam, William Nile Jr, *Alexandria*
Eller, Joseph Johnson, *Marion*
Eller, Myron Edward Jr, *Martinsville*
Ellington, David Alan, *Lexington*
Elliott, Robert I, *Forest*
Ellis, John Wesley, *Purcellville*
Ellis, John Wesley Jr, *Oakton*
Elward, Kurtis Scott, *Virginia Beach*
Emerine, Ollie Bennett, *Chantilly*
Eng, Benjamin P, *Norfolk*
Enright, Rosemary Theresa, *Manassas*
Epperson, Thomas I Jr, *Dillwyn*
Eppes, Thomas W Jr, *Forest*
Ernst, Arthur Clifford, *Richmond*
Eure, L Brinkley, *Pulaski*
Evans, Bryan Dean, *Newport News*
Evans, Coleen G, *Richmond*
Evans, James Dewitt, *Harrisonburg*
Evans, James G, *Virginia Beach*
Evans, Paul Edward III, *Newport News*
Evans, Robert Bruce, *Richmond*
Everett, John Clayton, *Virginia Beach*
Falkenstein, Richard C II, *Middleburg*
Falls, Randall Keith, *Roanoke*
Fay, Linda Anne, *Alexandria*
Fedro, Randall Craig, *Chesapeake*
Feely, Robert Everett Jr, *Newport News*
Feldmann, Spencer G Jr, *Manassas*
Fenderson, Allen R, *Virginia Beach*
Ferguson, William, *Suffolk*
Fergusson, Kevin W, *Richmond*
Fernando, Joseph Ernest, *Vienna*
Ferraraccio, Ponziano P, *Pulaski*
Fierro, Anthony, *Richmond*
Fieseler, Catherine Mary, *Alexandria*
Filak, Michael Andrew, *Centreville*
Fish, James A Jr, *Yorktown*
Fisher, C L Jr, *Hampton*
Fleenor, Lawrence J, *Big Stone Gap*
Fleisher, Mitchell Allan, *Blackstone*
Fletcher, Donald F Jr, *Atlantic*
Fletcher, William Paul, *Harrisonburg*
Flint, Laurie Ann, *Bedford*
Foos, Robert Edward Jr, *Hayes*
Forrester, J Colin, *Callao*
Foster, Glen G, *Galax*
Fox, Diane Guenin, *Crewe*
Fratrick, Albert Andrew, *Appomattox*
Frazer, William Penn, *Hamilton*
Frazier, Maurice W, *Hampton*
Freeman, Elias Thomas, *Chesapeake*
Freeman, John R, *Richmond*
Friedberg, Isadore Hirsh, *Richmond*
Frieden, Harry M, *Norfolk*
Friedland, Melissa Schwab, *Alexandria*
Friedler, Edward M, *Annandale*
Fritz, Robert L, *Charlottesville*
Gable, Janice Ruth, *Damascus*
Gallini, Marc Robert, *Lorton*
Garber, Vera R, *Alexandria*
Garcia, Raul R, *Vienna*
Gardner, Charles W Jr, *Alexandria*
Gardner, Joseph E, *Harrisonburg*
Garfinkel, Daniel Paul, *Falls Church*
Garrison, Jack Stiles, *Virginia Beach*
Gibb, C Ernest Jr, *Nassawadox*
Gibson, Robert John, *Alexandria*
Gilliam, Darrell Kay, *Richmond*
Gilmer, Giles Q, *Lebanon*
Gingerich, Keith Alan, *Bastian*
Ginsburgh, Charles Lee, *Newport News*
Ginther, Jeffrey Paul, *Bristol*
Glick, John T, *Shenandoah*
Glynn, Simone Agnes, *Fairfax*
Goforth, Gary Alan, *Woodbridge*
Goings, Ronald Steven, *Clifton Forge*
Goldin, Milton, *Portsmouth*
Goldman, Jill Hillmar, *Roanoke*
Goldsmith, Geoffrey A, *Norfolk*
Gonzalez, Michael Stephen, *Chesapeake*
Gonzalo, Toti P, *Newport News*
Good, John Russell, *Richmond*
Goode, Harvey W Jr, *Kilmarnock*
Goodman, Allan J, *Virginia Beach*
Goodnight, Robert Henry, *Farmville*
Goodwin, Selwyn David, *Richmond*
Gordon, Jane Christine, *Columbia*
Gordon, Rufus H, *South Boston*
Gouldin, Thomas Winston, *Norfolk*
Grabeel, William S, *Gordonsville*
Graham, Louis B, *Lynchburg*
Graham, Mary Olive, *Norfolk*
Grandis, Stuart Victor, *Richmond*
Grant, Thomas Russell Jr, *Norfolk*
Grayson, Wayne E, *Roanoke*
Gregory, Fleta A, *Portsmouth*
Gremer, John Samuel, *Tabb*
Griffith, Frederick Phillip III, *Middleburg*
Griffith, Lloyd Tayloe, *Mt Holly*
Gruber, Brian L, *Suffolk*
Gruenther, Raymond Carl, *Springfield*
Grund, Bruce M, *Manassas*
Guay, Walter Wilfred, *Bena*
Guilaran, Eddie Z, *Covington*
Gwathmey, Pamela Lester, *Roanoke*
Haden, Charles Benjamin Jr, *Gum Spring*
Haga, David S, *Madison Heights*
Hagan, Christine D, *Richmond*
Hagan, Margaret Lee, *Vinton*
Hagood, Warren C, *Clover*
Hagood, William J Jr, *Clover*
Hagy, John Albert, *Rocky Mount*
Haley, James Adams, *Harrisonburg*
Hall, Richard Benfield II, *Norfolk*
Hall, Roy Everette, *Virginia Beach*
Hall, Roy Peter, *Newport News*
Hallmann, Clemens E, *Richmond*
Hamilton, Thomas Francis, *Covington*
Hamlor, Gahear F, *South Boston*
Hampton, H M, *Weber City*
Hanfling, Carl Jr, *Annandale*
Hanks, Carl Eugene Jr, *Wytheville*
Hanna, Edward Stanley, *Chesapeake*
Harcus, Sinclair John Jr, *Martinsville*
Hardt, Anthony B, *Virginia Beach*
Harper, G William III, *Harrisonburg*
Harper, Michael Roy, *Woodstock*
Harrington, William G, *Richmond*
Harris, Andrew Epes Jr, *Blackstone*
Harris, Charles Larry, *Chesapeake*
Harrison, William Henry, *Lawrenceville*
Harvey, Kevin M J, *Midlothian*
Harvey, Lorena Limon, *Midlothian*
Haskell, Edward G Jr, *Virginia Beach*
Hatch, Karen Marie, *Midlothian*
Hatter, Dennis L, *Stuarts Draft*
Hayes, Henry Desmond, *Norfolk*
Hays, Richard Beckman, *Charlottesville*
Head, Murdock, *Warrenton*
Heatwole, Kenneth Michael, *Waynesboro*
Hedges, David Joe, *Blacksburg*
Hedlund, Linda Margaret, *Falls Church*
Hedrick, Thomas B, *Buena Vista*
Heiby, Laura Rae, *Virginia Beach*
Heiskell, Lawrence Eldred, *Roanoke*
Helm, John W, *Hampton*
Henderson, Clifford E, *Williamsburg*
Henderson, June Rose S, *Williamsburg*
Hendricks, William Tillman Jr, *Blacksburg*
Henley, Marlene B, *Rocky Mount*
Herring, Angela, *Newport News*
Hertzler, Charles W, *Harrisonburg*
Hinson, Claude Randolph Jr, *Richmond*
Hoffman, John Allen, *Lynchburg*
Hoffman, John Feland, *Woodstock*
Hofford, Roger A, *Lynchburg*
Hogan, Elizabeth Wright, *Alexandria*
Holland, John A Jr, *Emporia*
Holliday, Taylor Duke, *Castlewood*
Holsinger, James R, *Luray*
Holt, David B, *Virginia Beach*
Honablue, Richard Riddick, *Williamsburg*
Hooker, Raymond C Jr, *Richmond*
Hoq, Kasedul, *Portsmouth*
Horden, Harold Milton, *Norfolk*
Horn, Henry J, *Annandale*
Horne, Allen Bernard, *McLean*
Horne, Edwin George Jr, *Virginia Beach*
Horne, Wallace J, *Alberta*
Horney, Wayne D, *Wytheville*
Hornick, Lawrence Ernest, *Carrollton*
Hosfield, Richard H, *West Point*
Hoshino, David Ken, *Oak Hall*
Howard, Vaughan H Jr, *Williamsburg*
Howe, Allen K Jr, *Herndon*
Huang, Angeline Hooi Teen, *Falls Church*
Hubach, Frederick Willis, *McLean*
Huber, Albert L, *Charlottesville*
Hudgins, David Michael, *Virginia Beach*
Huffman, Frank Harrison, *Newport News*

Family Practice *(cont'd)*

Huffman, Harold E, *Hinton*
Huffman, Rufus Clyde, *Bridgewater*
Hundley, Willoughby Shelton III, *Boydton*
Hunley, Richard L, *Richmond*
Hunter, Robert Hampton, *Hampton*
Hutchison, Wayne Thomas, *Bedford*
Iden, Thomas Carroll, *Berryville*
Ignacio, Eleodora C Merle, *Chesapeake*
Irvin, Stephen Brooks, *Galax*
Irvin, Stephen Brian, *Dryden*
Irwin, Charles Fayette, *Richmond*
Ivey, Henry Reese Jr, *Vinton*
Jackson, William George, *Suffolk*
Jacobs, Lacey M Jr, *Richmond*
Jamison, Bernard Francis, *Smithfield*
Janczewski, Mark George, *Norfolk*
Jennings, Eileen Thorpe, *Bedford*
Jenrette, Freeman Wesley, *Bedford*
Jesneck, Edward Joseph, *Bassett*
Jeter, William Richard, *Richmond*
Jewell, Thomas David, *Blue Ridge*
Jocson, Dante N, *Manassas*
Johns, Sonja Maria, *Warsaw*
Johns, Stephen Paul, *Newport News*
Johnson, David Lewis, *Fredericksburg*
Johnson, Douglas Russell, *Virginia Beach*
Johnson, Frank Joseph Jr, *Bluefield*
Johnson, Holly Ann, *Lynchburg*
Johnson, Mariann H, *Richmond*
Johnson, Norris J, *Ettrick*
Johnson, Robert Kellogg, *Richmond*
Johnson, Tommy, *Hampton*
Johnson, Vanessa O, *Fredericksburg*
Jokl Magurno, Justine Ann, *Richmond*
Jones, Daniel Ralph, *Vinton*
Jones, Harriett Hundley, *Newport News*
Jones, Jo Allen, *Woodstock*
Jones, Kurt Dominic, *Chesapeake*
Jones, Robert Mark, *Edinburg*
Jones, Samuel Moseley, *Burke*
Jones, Webb D, *Newport News*
Jones, William Garnett, *Brookneal*
Joyce, John Owen, *Virginia Beach*
Joyce, Richard Alvis, *Charlottesville*
Joynes, Michael Hope, *Hampton*
Judson, John H, *Falls Church*
Judy, Samuel Benjamin, *Clarksville*
Kabal, John, *Great Falls*
Kagan, Larry Howard, *Chesapeake*
Karmarkar, Devdass Dattatraya, *Charlottesville*
Kawase, Yutaka, *Lebanon*
Kazi, Sayed Salahuddin, *Midlothian*
Keegan, Jeffrey M, *Richmond*
Keenan, Robert E, *Richmond*
Keiderling, Edward Martin, *Clintwood*
Keim, Melvin N, *Staunton*
Kelleher, Kevin Charles, *Roanoke*
Keller, Kevin Achille, *Midlothian*
Keller, Lawrence Edward, *Orange*
Kelly, Daniel R, *Radford*
Kelly, Daniel Raymond, *Roanoke*
Kelsey, Gerdi D, *Virginia Beach*
Kennedy, Brian D, *Waynesboro*
Kennedy, Lisa Shea, *Virginia Beach*
Kensell, Ralph F, *Harrisonburg*
Kent, J Paul, *Altavista*
Kerns, John William, *Front Royal*
Keyes, Janice L, *Centreville*
Khan, Abdur Rasheed, *Virginia Beach*
Khan, Eu-Eng Nikhat, *Burke*
Kiessling, Brenda R, *Arlington*
Killen, Joseph F Jr, *Virginia Beach*
Kincaid, Scott A, *Radford*
Kintigh, James William, *Newport News*
Kirby, Emerson Lynn, *Richlands*
Kirkland, C Stokes Jr, *Norfolk*
Kirkland, Nathaniel C Jr, *Maurertown*
Kiser, Kenneth David, *Big Stone Gap*
Kitchen, Robert Henry, *Fairfax Station*
Knight, Donald A, *Earlysville*
Kniss, Mark Allen, *Harrisonburg*
Koenig, Carol Lynn, *Onley*
Kowalski, John Peter, *Richmond*
Kramer, Marc Stephen, *Richmond*
Kraus, Harry Lee, *Harrisonburg*
Krebser, Werner, *Huntly*
Kruger, Howard I, *Norfolk*
Kuiken, Garry H, *Floyd*
Kuo, Hwang Ren, *Chesapeake*
Kurylas, Stephen Charles, *Alexandria*
Kuykendall, Harry C, *Alexandria*
Lagan, Henry Duane, *Blacksburg*
Laibstain, Robert B, *Chesapeake*
Laky, Joan Carol Trost, *Alexandria*
Lamb, Charles E, *Roanoke*
Lanford, Randolph E, *Fork Union*
Lanham, John Louis, *Charlottersville*
Laremont, Benjamin, *Norfolk*
Larson, Steven D, *Herndon*
Latham, Bernice Grant, *Richmond*
Latimer, Robert A W Jr, *Manassas*
Laughlin, Paul H, *Richmond*
Law, Katherine P, *Virginia Beach*
Lawrence, Daniel Clinton, *Richmond*
Lawrence, Duane Arthur, *Virginia Beach*
Layman, David Arthur, *Hopewell*
Le, Lac Kim, *Midlothian*
Leavens, Deborah Irene, *Herndon*
Lebow, Howard M, *Salem*
Ledwith, James J Jr, *Tappahannock*
Lee, Thaddeus Carmichael, *Radford*
Lekwuwa, Okafor Mang, *Danville*
Lenker, Leon E, *Staunton*
Lesnett, James Curtis, *Bluefield*
Lewis, Augustine W, *Aylett*
Lewis, Cyrus P, *Lynchburg*
Lewis, David Owen, *Martinsville*
Lewis, Steven T, *Rocky Mount*
Lewis, Wallace Emory Jr, *Reedville*
Lieberman, Michael David, *Alexandria*
Lim, Eric W, *Blacksburg*
Lindsay, Richard Walter, *Charlottesville*
Little, Dwight D, *Lynchburg*
Little, Paul B, *Alexandria*
Litton, Darlene E B, *Big Stone Gap*
Lockwood, James Joseph, *Norfolk*
Logan, Anne Jones, *Somerset*
Lohkamp, Irene Stavrou, *Newport News*
Love, Suzanne S, *Virginia Beach*
Lowry, Mann T, *Montpelier*
Lucas, Kenneth W Jr, *Richmond*
Luck, James Thomas, *Damascus*
Luh, Albert Hung-Pei, *Lynchburg*
Lundie, Donald Wayne, *Smithfield*
Luth, Janice Elaine, *Moneta*
Lyle, Lurton Braxton, *Clintwood*
Lynch, George Michael, *Herndon*
Lynch, James Patrick, *Virginia Beach*
Lyons, Sidney Jr, *Arlington*
Macfarlan, Duncan Andrew, *Earlysville*
Mackie, Lora Elise, *Fairfax*
Mahon, Ellen Ruth, *Portsmouth*
Maizel, David R, *Virginia Beach*
Makari, Doris Angelina, *Alexandria*
Manlapaz, Carolina Paredes, *Alexandria*
Mansy, Joseph M, *Centreville*
Mapp, John Alfriend, *Virginia Beach*
Markham, Harold William, *Culpeper*
Markle, William Howard, *Mannboro*
Marotta, Raymond Paul, *Charlottesville*
Marsh, Michael S, *Dayton*
Marshall, John Lyons, *Newport News*
Martin, Arthur J, *Bowling Green*
Martin, Diana, *Fairfax*
Martin, Moir Glenwood, *Hillsville*
Martin, William Dabney IV, *Richmond*
Massey, David Q, *Stuarts Draft*
Mathews, John A, *Appomattox*
Mathis, Davis M, *Leesburg*
Maughan, George Toping, *Richmond*
Maybach, Eric J, *Warrenton*
Mayberry, Barry Marshall, *Hillsville*
Mayo, Fitzhugh, *Richmond*
Mayo, William F, *Dublin*
Mc Allister, Russell Sr, *Richmond*
Mc Anulty, David Allen, *Troy*
Mc Carter, Brenda Williams, *Amelia*
Mc Carter, Warren J, *Richmond*
Mc Carthy, William C, *Woodbridge*
Mc Cord, Ronald S, *Manakin Sabot*
Mc Cormally, Terence James, *Herndon*
Mc Cready, Daniel R, *Virginia Beach*
Mc Cutcheon, Randolph Jr, *Richmond*
Mc Daniel, Leroy S, *Bon Air*
Mc Dowell, James Everett, *Marion*
Mc Elmurray, Charles Tyner, *Bluefield*
Mc Ghee, James Stuart, *Ft Belvoir*
Mc Gough, Thomas F, *Alexandria*
Mc Gowan, Gary Douglas, *Richmond*
Mc Guire, Erma M, *Pearisburg*
Mc Ilwaine, Benjamin H, *Sutherland*
Mc Kay, James, *Richmond*
Mc Lanahan, Sandra Martin, *Buckingham*
Mc Laughlin, Debra Banks, *Virginia Beach*
Mc Mahon, Doreen E, *McLean*
Mc Mahon, Michael A, *Pearisburg*
Mc Nett, Wayne Franklin, *Bridgewater*
Mc Pherson, David P, *Hillsville*
Mc Pherson, Douglas Lynn, *Wilsons*
Meadows, Glenn I, *Lynchburg*
Medder, Jimmy Dean, *Norfolk*
Meixel, Steven A, *Charlottesville*
Mendel, Peter Allan, *Dumfries*
Mercer, Harry R, *Glen Allen*
Merle-Ignacio, Eleodora C, *Chesapeake*
Merrick, Randolph Vaughan, *Orange*
Merrill, Cynthia Westneat, *Richmond*
Metzler, Keith Alan, *Lynchburg*
Miller, Bruce Allen, *Hopewell*
Miller, David Brooke, *Richmond*
Miller, David C, *Leesburg*
Miller, Gerald Erb, *Harrisonburg*

Family Practice *(cont'd)*

Miller, James Wesley, *Richmond*
Miller, Mitchell B, *Virginia Beach*
Miller, Richard B, *Stuarts Draft*
Miller, Ronald E, *Hopewell*
Miller, Samuel E, *Abingdon*
Miller, Stephen Allen, *Virginia Beach*
Miller, Susan Ann, *Midlothian*
Miraglia, Colleen Patricia, *Charlottesville*
Mitchell, George Stanley, *Newport News*
Mitchell, Larry G, *Richlands*
Mizrach, Glenn Brian, *Glen Allen*
Mokede, Catherine Ruth, *Midlothian*
Moomau, George Benjamin, *Winchester*
Moore, Carolyn Ann, *Mint Spring*
Moore, Christopher Timothy, *Roanoke*
Moore, Clifton M, *Norfolk*
Moore, D Parker III, *Chester*
Moore, Desaussure P Jr, *Hopewell*
Moore, Earle Winston, *Chase City*
Moore, Gloria L, *Norfolk*
Moore, Patricia Hughes, *Norfolk*
Moore, Stephen Lee, *Oak Hall*
Moore, William Francis, *Richmond*
Moreno, Leopold S, *Norfolk*
Moreshead, Jon Ashton, *Bridgewater*
Morgan, Stephen Alderton, *Roanoke*
Morgenstern, Jeffrey H, *Falls Church*
Moro, Michael V, *Virginia Beach*
Morrissette, W P, *Midlothian*
Morrissette, William P III, *Midlothian*
Morse, Robert Michael, *Charlottesville*
Moscoe, Jay E, *Banco*
Moses, Fredrick Mathi, *Wytheville*
Moss, Audrey Arnold, *Arlington*
Mowe, Deborah Ann, *McLean*
Moyer, Frank Rabe, *Fairfax*
Muffelman, David W, *Yorktown*
Muller, John G, *Richmond*
Mulligan, Edward Kieran, *Woodstock*
Mullins, Benny Carroll, *Bristol*
Mumper, James D, *Mechanicsville*
Murphy, Kevin Paul, *Woodbridge*
Murray, William Olanda, *Tazewell*
Myers, Russell H, *Midlothian*
Nader, Jafar, *Blacksburg*
Nagel, Jill Elaine, *Newport News*
Nagell, Scott H, *Sterling*
Naranjo, Jorge A, *Boykins*
Nash, Beverly W, *Timberville*
Natalio, Nestor Fuentes, *Portsmouth*
Neifeld, David M, *Hopewell*
Nelson, Jane Ellen, *Alexandria*
Nelson, Thomas Harlan, *Hampton*
Neustatter, Patrick Lindesay, *Fredericksburg*
Nevarez, Leonard Joseph, *McLean*
Nevin, Marc G, *Salem*
Newby, James Edward II, *Norfolk*
Newman, Robert J, *White Stone*
Newton, David Emory, *Newport News*
Nguyen, Diem Duc, *Williamsburg*
Nguyen, Liem Thanh, *Williamsburg*
Nichols, David B, *White Stone*
Nobu, Amy Yoshiko, *Fairfax*
Noller, William Edward, *Arlington*
Nolley, Eugene Davis, *Churchville*
Norfleet, Benjamin E, *Newport News*
Norfleet, Stephen M, *Newport News*
Nottingham, Clifford III, *Roanoke*
Novotny, Thomas Edward, *Alexandria*
Nuckols, William A, *Abingdon*
Nunley, Wallace Clay, *Clifton Forge*
Ober, William C, *Crozet*
O'Brien, Lynn Murphy, *Fairfax*
Okin, Michael Allen, *Lynchburg*
Olin, Richard T, *Woodbridge*
Ong, Arsenio Manlangit, *Virginia Beach*
Overstreet, Ronald B, *Blue Ridge*
Overton, Eugene W, *Fairfax*
Owen, John Thomas, *Richmond*
Owens, Patricia Ann, *Harrisonburg*
Page, David Elliott, *Alexandria*
Paisan, Carlos Manuel, *Newport News*
Paquette, Joseph D, *Fredericksburg*
Parham, Louis Daniel Jr, *Hampton*
Parson, Michael I, *Newport News*
Pascasio, Ernesto Agustin, *Bluefield*
Pasley, Faith R, *Roanoke*
Pastor, Larry Howard, *Falls Church*
Patten, Robert Chester, *Troutville*
Patterson, James E, *Marion*
Patterson, James L Jr, *Pulaski*
Pauswinski, John Robert, *Manassas*
Pauze, John Alexander, *Roanoke*
Payling-Wright, Charles Richard, *McLean*
Peck, Thomas Stuart, *Fairfield*
Penalosa, Leocadio B Jr, *Chesapeake*
Peralta, Antonio M, *Richlands*
Perez, Michael David, *Burke*
Perkins, Bryan Keith, *Roanoke*
Perlman, Jerome David, *Norfolk*
Perry, William J, *Williamsburg*
Pet, Leo T, *Norfolk*
Peterson, Phillip Allen, *Bluefield*
Petri, Mary Ann Mcdonald, *Aylett*
Petrizzi, Michael J, *Mechanicsville*
Phelan-Adams, Anne Louise, *Blacksburg*
Phillips, Doyle Claude, *Blackstone*
Phillips, Frank Harrison, *Charlottesville*
Phillips, Robert M, *Chester*
Phillips, Stephen Lee, *Elkton*
Phipps, William James, *Blackstone*
Picardi, Mary Catherine, *Norfolk*
Piland, Jethro H Jr, *Mechanicsville*
Pillai, Thankam Biswanath, *Suffolk*
Plaster, Burton Clay, *Charlottesville*
Plescia, Marc Gian, *Herndon*
Pletke, Patricia Ann, *Lynchburg*
Plunkett, Harry G Jr, *Virginia Beach*
Plyler, Marion T Jr, *Suffolk*
Podolnick, Nelson, *Falls Church*
Podosek, Alan M, *Lynchburg*
Poehlman, George S, *Leesburg*
Pollart, Susan Marie, *Charlottesville*
Pommerenke, Forrest Alan, *Annandale*
Pope, John Henry Jr, *Richmond*
Port, Brian R, *Chester*
Pote, Douglas Allyn, *Marion*
Poulsen, Wendell T, *Grafton*
Powell, Clarence L Jr, *Franklin*
Powell, Kenneth A, *Appomattox*
Powell, Robert G, *Ashland*
Powers, Randolph S, *Winchester*
Powers, Thomas Jefferson Jr, *Williamsburg*
Powledge, Darrell F, *Salem*
Pressley, Rhonda Darlene Hill, *Dahlgren*
Price, James Guy, *Norfolk*
Price, Jerry Theodore, *Lynchburg*
Purcell, William Vernon III, *Powhatan*
Pyles, Alice Elizabeth, *Richmond*
Quarles, John M, *Newport News*
Quinn, Karen L, *Shawsville*
Rabon, Fred Scott, *Charlottesville*
Rafey, Ernest George, *Falls Church*
Rafter, Jack Roy, *Winchester*
Ramsey, Roscoe William Jr, *Williamsburg*
Rao, Jyoti, *Virginia Beach*
Raynor, Robert C, *Afton*
Reach, John Salvatore, *Palmyra*
Reach, Ralph Thomas, *Roanoke*
Read, Louis John, *Lynchburg*
Read, Stephen George, *Richmond*
Redding, Richard James, *Alexandria*
Redington, James Franklin, *Hot Springs*
Reinhardt, Stephen D, *Richmond*
Rejzer, Ronald John, *Hampton*
Rennie, Victoria Attkisson, *Richmond*
Rexrode, Norman L, *Lebanon*
Reynolds, George A, *Bowling Green*
Reynolds, Thomas Earl, *Culpeper*
Rhea, Randall R, *Vinton*
Ricohermoso, A Z, *Chesapeake*
Riley, P Thomas, *Midlothian*
Rill, Michael Philip, *Fairfax*
Rinehart, Stephen Roy, *Tazewell*
Rivera-Cassell, Nancy Dennisse, *Norfolk*
Roberts, Allen Hunt II, *Alexandria*
Roberts, Kevin William, *Oak Hall*
Robertson, Kenneth J, *Williamsburg*
Robinson, Frederick L II, *Newport News*
Robinson, James W, *Salem*
Robinson, Lucian D, *Blacksburg*
Rodgers, Joseph Lewis Jr, *Blackstone*
Rodman, James M, *Madison Heights*
Rogney, Douglas Lloyd, *Wytheville*
Rollins, James Andria, *Richmond*
Romano, Michele Alana, *Fairfax*
Romero, Aleli G, *Virginia Beach*
Rono, Vicente Narzoles Jr, *Virginia Beach*
Ross, Meredith Richmond, *Roanoke*
Ross, Wesley Jay, *Waynesboro*
Rosso, Ritchie O, *Virginia Beach*
Rouhier, Charles Richard, *Midlothian*
Roundtree, Silverrene Phillips, *Virginia Beach*
Roure, Rafael A, *Virginia Beach*
Rowe, Henry C, *Hayes*
Roy, Kanak Ratan, *Virginia Beach*
Royston, Norris A, *Marshall*
Rucker, Elsy, *Suffolk*
Rul-Lan, Carlos D, *Glen Allen*
Rupke, Stuart J, *Lebanon*
Ryan, John Thomas, *Fredericksburg*
Ryan, Regina M, *Midlothian*
Ryu, Jai Yol, *Alexandria*
Sager, Anita Louise, *Norfolk*
Sakakini, George Constant, *Chincoteague*
Salb, John P, *Virginia Beach*
Salinas, Orlando F, *Blacksburg*

Family Practice *(cont'd)*

Salumbides, Maria Cristina Javier, *Virginia Beach*
Samaras, Thomas A, *Virginia Beach*
Sanders, Donald Powell, *Richmond*
Sargent, Donald Lee, *Dale City*
Satchwell, Susan H, *Newport News*
Saunders, Mary S, *Mechanicsville*
Savellano, Dante G, *Hopewell*
Saxon, David Henry, *Wytheville*
Saylor, Edward M, *Richmond*
Schanzer, Harriet, *Richmond*
Schenck, Marcus David, *Culpeper*
Schenk, Maryjean, *Onancock*
Schmidt, Gilbert Francis Jr, *Virginia Beach*
Schmitz, Nancy Ann, *Crozet*
Schneider, Linda Pace, *Hampton*
Schober, Anna Marie, *Danville*
Schonzeit, Darin Carla, *Fairfax*
Schubert, Ronald L, *Dayton*
Schufeldt, Susan Taich, *Richmond*
Schwartz, David G, *Louisa*
Schwartz, Wendy Nina, *Arlington*
Scott, Howard Carlisle, *Richlands*
Seiler, Sigmund Placid, *Midlothian*
Semendy, Valeri, *Fairfax*
Senter, James P, *Clintwood*
Servideo, Joseph G, *The Plains*
Settle, Paul Cox, *Danville*
Shacochis, Thomas J, *Tabb*
Shafer, William H, *Richmond*
Shank, David L, *Harrisonburg*
Sharp-Warthan, Jennifer, *Newport News*
Sheahan, William Thomas, *Newport News*
Shelton, Aubrey L, *Norfolk*
Shenk, Jonathan D, *Waynesboro*
Shepherd, Richard D, *Blacksburg*
Sherrill, John Doke III, *Bristol*
Sherrod, John Philip, *Beaverdam*
Shlifer, Susan Jalland, *Manassas*
Shmorhun, Eugene A, *Annandale*
Short, Timothy Burns, *Afton*
Showalter, Samuel Getz, *Weyers Cave*
Shrader, William Eric, *Tazewell*
Sigfred, Sture Vivian Jr, *Norfolk*
Silverstein, Michael Albert, *Herndon*
Silvester, Michael J, *Orange*
Sim, Hua-Chuan, *Norfolk*
Sim, Peter Alan, *Newport News*
Simpson, Kenneth R Jr, *Mechanicsville*
Simpson, Melvin R, *Newport News*
Skaggs, Jerome D, *Hopewell*
Slaughter, Arthur Robert, *Roanoke*
Slusher, Ralph Charles, *Altavista*
Smith, Alan Michael, *Prince George*
Smith, Barton Palmer, *Petersburg*
Smith, Bill Moore, *Roanoke*
Smith, Charles Kent, *Norfolk*
Smith, David M, *Forest*
Smith, Donald Craig, *Wytheville*
Smith, Donald George Jr, *Roanoke*
Smith, George Robert Jr, *Shawsville*
Smith, Howard C Jr, *Virginia Beach*
Smith, James R, *Wytheville*
Smith, Jeffrey P, *Virginia Beach*
Smith, Joseph Douglas, *Bridgewater*
Smith, Richard A, *Charlottesville*
Smith, Richard H Jr, *Harrisonburg*
Smith, Robert Sullins, *Richmond*
Smith, Steven Donis, *Stanley*
Smith, Stuart A, *Glade Spring*
Smith, Stuart James, *Hampton*
Smith, William Scott, *Moseley*
Smithson, Peter W, *Richmond*
Snider, Gary Boyd, *Norfolk*
Snyder, Christopher III, *Leesburg*
Snyder, Jeanne Marie, *Richmond*
Snyder, John W Jr, *Nassawadox*
Sokol, Richard A, *Norfolk*
Solan, Stuart Miley, *Richmond*
Solin, Michael E, *Leesburg*
Solinap, Perla Juaneza, *Norfolk*
Soria, Estanislao Venezuela Jr, *Virginia Beach*
Southall, Alger Rixey III, *Louisa*
Southall, Kirby Donaldson, *Petersburg*
Sowder, Charles Robert, *Mechanicsville*
Sparrow, Charles Kavanaugh, *Quinton*
Spence, Steven, *Blackstone*
Sperry, Thomas Howard, *Virginia Beach*
Spiers, Leon Otis III, *Richmond*
Spivey, David Eugene Jr, *Roanoke*
Sprinkle, Edward P, *Martinsville*
Squire, Peter W, *Emporia*
Squires, William A, *Richmond*
Stairs, Paul Whitney, *Beaverdam*
Stallings, William D, *Virginia Beach*
Stanford, Sam Raymond Jr, *Gloucester*
Stanford, Walter J, *Galax*
Stauffer, John M, *New Market*
Stavola, Anthony R, *Roanoke*
Stein, Karlton A, *Waynesboro*
Steinmetz, Marie Frances, *Alexandria*
Stennett, Thomas Reginald III, *Chester*
Stensland, Mark S, *Midlothian*
Stern, Kelly Luther, *Drakes Branch*
Stevens, James Romer, *Falls Church*
Stewart, Robert Jennings, *Newport News*
Still, Gregory Lewis, *New Castle*
Stockburger, Robert W, *Blacksburg*
Stoker, Michael Hughes, *Max Meadows*
Stokes, Parker Rea, *Hampton*
Stokes, Robert Lee, *Charlottesville*
Stone, James Banister III, *Wytheville*
Strong, Robert S, *Rocky Mount*
Stroud, Stephen Briggs, *Virginia Beach*
Sughrue, Maura Jean, *Fairfax*
Sulkowski, Thomas Edward, *Midlothian*
Sullivan, Thomas Stephen, *Fairfax*
Sutelan, Harry E, *Norfolk*
Sutton, Charles E, *Richmond*
Swecker, Charles E, *Roanoke*
Sweet, William Edward, *Roanoke*
Szucs, Richard Alexander, *Richmond*
Tam, Henry Wing Sek, *Dungannon*
Tate, Glen Edward, *Laurel Fork*
Tate, Kelly Sheridan, *Roanoke*
Taylor, Clarence Waldo, *Shawsville*
Taylor, Gregory Wayne, *Fredericksburg*
Taylor, Herbert T III, *Strasburg*
Taylor, Michael Paul, *Richmond*
Taylor, Smith Davis, *Fincastle*
Tennant, Bradley F, *Virginia Beach*
Theby, Janet Elaine, *Charlottesville*
Theis, Richard B, *Williamsburg*
Thekkethala, Kuriakose V, *Richmond*
Thomas, Brant W, *Virginia Beach*
Thomas, Dennis Lee, *Sandston*
Thompson, Chad Randal, *Blacksburg*
Thompson, Girard Vaden, *Chatham*
Thompson, James R, *Tazewell*
Threlkeld, William L, *Poquoson*
Tidaback, Dale Roger, *Chesapeake*
Tingle, Norman R Jr, *Lively*
Tingle, Norman R Sr, *Lively*
Titus, Jonathan Jr, *Alexandria*
Toewe, Clinton H II, *Norfolk*
Tokarz, John Pat, *Alexandria*
Toney, Ronald W, *Richmond*
Toothman, Clara Jane, *Bristol*
Townsend, Thomas E, *Independence*
Troxel, Frederick Louis, *Dublin*
Troxel, James Roy, *Winchester*
Tschan, Donald N, *Gloucester Point*
Tucker, Alton G, *Burke*
Tucker, William Travis Jr, *Richmond*
Tunstall, June R, *Surry*
Turner, Paul E Jr, *Newport News*
Tweel, William Theodore, *Mechanicsville*
Uhl, Shirley Elizabeth, *New Port News*
Ussery, Carol Birkhead, *Richmond*
Van Geertruyden, Herman Hendrik, *Norfolk*
Van Ness, Madge Bruce, *Lorton*
Van Slyke, Gary Lee, *Virginia Beach*
Varner, Lawrence C, *Farmville*
Vaughan, John Watt, *Virginia Beach*
Vaughan, Robert Wylder, *Richmond*
Vaughan, Stephen F, *Petersburg*
Velena, Samson, *Falls Church*
Veney, Herbert L, *Warsaw*
Ventzek, Albert Theodore, *Woodbridge*
Vinh, Luc, *Virginia Beach*
Vinsel, Jeanne M, *Richmond*
Vom Lehn, Walter Otte, *Christiansburg*
Von Clef, Julius Sumner III, *Staunton*
Von Elten, Steven W, *Warrenton*
Vuurmans, Coenraad, *Fries*
Waddell, David Thomas, *Virginia Beach*
Waddell, William Bryan, *Galax*
Wade, Terrill Joy, *Richmond*
Wake, Gary Wentworth, *Winchester*
Walker, George, *Marion*
Walker, Kenneth Joseph, *Pearisburg*
Wallace, M Brevard III, *Culpeper*
Walter, Gail Elizabeth, *Roanoke*
Ward, C Harper, *Montross*
Ward, Joseph Lawson, *Hampton*
Ward, William C, *Roanoke*
Ware, Henry Mc Wane, *Newport News*
Warne, Charles Harvey, *Virginia Beach*
Warren, George Hugh Jr, *Newport News*
Weathington, Lee II, *Hopewell*
Weaver, Kevin Michael, *Herndon*
Weaver, Wayne M, *Weyers Cave*
Wedd, George G, *Richmond*
Weddle, William E, *Buena Vista*
Weger, Marvin Louis, *Richmond*
Weidig, George Louis Jr, *Harrisonburg*
Wein, Barry K, *Mechanicsville*
Weinberg, Howard N, *Virginia Beach*
Weirich, Gordon Dale, *Weyers Cave*
Weisman, Todd Andrew, *Hampton*
Welsh, James Charles, *Ladysmith*

Family Practice *(cont'd)*

Wenger, Wade L, *Staunton*
Werner, Wallace James, *Manassas*
Westberg, Milton Delin, *Montross*
Westfall, Roger K, *Front Royal*
Wheeler, Robert Milton, *Richmond*
Whitacre, Samuel N, *Winchester*
White, Craig Justice, *Charlottesville*
White, Edward S, *Bloxom*
White, Julian Andrews, *Virginia Beach*
White, Patricia Schaffer, *Charlottesville*
White, Stuart Bruce, *Blackstone*
Whitehead, David C Jr, *Harrisonburg*
Wilcox, Howard Douglas, *Tabb*
Williams, Dixon C, *Pulaski*
Williams, Donald R, *Salem*
Williams, Gary S, *Big Stone Gap*
Williams, H Joseph, *Staunton*
Williams, Hazael J, *Staunton*
Williams, James Matthews, *Suffolk*
Williams, John Edward, *Lynchburg*
Williams, Marvin Thomas, *Midlothian*
Williams, Robert B, *Richmond*
Williams, Russell Warren, *Fredericksburg*
Williams, William C III, *Farmville*
Willing, Stephen A, *Farmville*
Willner, Henry S, *Fairfax*
Wilson, Alan David, *Norfolk*
Wilson, Gayle Ray, *Rapidan*
Wilson, Robert Whiting, *Herndon*
Wine, John Robert, *Burkeville*
Wineland, Richard H, *Kilmarnock*
Wingate, Angela L, *Petersburg*
Wingo, James T, *Hampton*
Winters, Mark Richard, *Virginia Beach*
Wittenberg, Samuel Harris, *Norfolk*
Wodicka, David Michael, *Lynchburg*
Wohler, Brett Alan, *Charlottesville*
Wolfe, James W, *Gate City*
Wolffe, Glenn Barnett, *Portsmouth*
Wolfrey, Jeffrey Douglas, *Earlysville*
Wolski, Eugene J, *Callao*
Wong, George Sonny, *Virginia Beach*
Wood, Maurice, *Roseland*
Wood, Robert Miguel, *Newport News*
Wood, Thomas Benton, *Lynchburg*
Woods, Paul A, *Waynesboro*
Wortley, George Cornelius, *Big Island*
Wright, Anna Mary, *Richmond*
Wright, Fletcher J Jr, *Petersburg*
Wright, William Jr, *Chesapeake*
Yang, William Norman, *Norfolk*
Yost, John W, *Vinton*
Young, Harold E Jr, *Orange*
Young, Jeffrey Bright, *Staunton*
Youse, Don C Jr, *Colonial Beach*
Zakaib, Edward Albert, *Richmond*
Zambrana, Benjamin F, *Richmond*
Zikel, Herbert M, *Newport News*

Forensic Pathology

Ballo, Joseph M, *Lovettsville*
Beyer, James C, *Falls Church*
Fierro, Marcella F, *Richmond*
Grauerholz, John Edward, *Leesburg*
Madge, Gordon Evans, *Richmond*
Ross, Gary W, *Charlottesville*
Sloop, Frank B Jr, *Charlottesville*
Wiecking, David K, *Richmond*

Gastroenterology

Adams, Kenneth Atwell, *Williamsburg*
Almond, Hilton Robinson, *Richmond*
Ansher, Alan F, *Alexandria*
Ashman, Berton William, *Virginia Beach*
Atiyeh, Maurice Nicola, *Alexandria*
Bashir, Abbas, *Falls Church*
Bell, J Sumner III, *Norfolk*
Brand, William T Jr, *Richmond*
Burnstein, Alan V, *Roanoke*
Buxton, Ernest P Jr, *Richmond*
Buxton, Ernest Perry III, *Newport News*
Cady, Allan Bartlett, *Richmond*
Caplan, Stephen Robert, *Norfolk*
Caravati, Charles Martin, *Richmond*
Catalano, Charles J, *Lynchburg*
Connell, Alastair M, *Richmond*
Cooper, James N, *Falls Church*
Costa, Boniface S, *Chesapeake*
Cramer, Alfred B, *Culpeper*
Dandalides, Steven M, *Norfolk*
Davis, Thomas Dewey Jr, *Richmond*
Diehl, Earl Henry Jr, *Richmond*
Dill, James E, *Roanoke*
Fallon, Harold Joseph, *Richmond*
Flis, Joseph F Jr, *Herndon*
Garone, Michael Alan, *Fairfax*
Gluckman, Jeffrey B, *Newport News*
Goldin, Norman R, *Portsmouth*
Gottfried, Irving S, *Farmville*
Gutierrez, Jose Antonio, *McLean*
Hanks, John Bright, *Charlottesville*
Herman, Gabriel Bryan, *Fairfax*
Hickman, Robert E, *Lynchburg*
Holt, Frank L Jr, *Richmond*
Hong, Young Sung, *Hampton*
Immel, Walter W, *Vienna*
Kessel, Ann T, *Richmond*
Kessler, George H Jr, *Winchester*
Kreger, David Lawrence, *Norfolk*
Leavell, Byrd S Jr, *Charlottesville*
Lee, Kok Seah, *Woodbridge*
Lilly, Edward Lewis, *Norfolk*
Miller, Paul I, *Woodbridge*
Mirkin, Kenneth R, *Fairfax*
Mitchell, Robert E III, *Richmond*
Mogadam, Michael, *Alexandria*
Monroe, Paul S, *Richmond*
Moore, Edward Weldon, *Richmond*
Morey, Dennis A J, *Richmond*
Morgan, John Edward, *Roanoke*
Morton, Robert E, *Fairfax*
Oblinger, Michael J, *Charlottesville*
Patteson, Thomas Earl III, *Front Royal*
Peters, Lawrence S, *Alexandria*
Pirmohamed, Moez L, *Fairfax*
Prugh, Merrill Frederick, *Alexandria*
Ramsey, Edward J Jr, *Richmond*
Ranard, Richard C, *McLean*
Regan, William Whitfield, *Richmond*
Respess, James C, *Charlottesville*
Robertson, Giles M Jr, *Richmond*
Rosenstein, Gladys, *Arlington*
Rosenstein, Herman, *Arlington*
Rustgi, Vinod Kumar, *Fairfax*
Sease, Robert H Jr, *Harrisonburg*
Shah, Kandarp K, *Virginia Beach*
Shauer, Alan B, *Alexandria*
Shiflett, Douglas W, *Danville*
Shoham, Myron Alan, *Vienna*
Small, Melvin D, *Mc Lean*
Soni, Anant B, *Wise*
Spainhour, Jack B Jr, *Danville*
Sperling, Michael H, *Norfolk*
Travers, Richard D, *Manassas*
Tregubov, Nikita, *Alexandria*
Vest, Steven L, *Big Stone Gap*
Vest, Timothy Keith, *Harrisonburg*
Vokac, Vaclav Albert, *Richmond*
Wall, George Hampton, *Salem*
Weiserbs, Dennis B, *Roanoke*
Weisiger, Benjamin B III, *Richmond*
Wolke, Anita, *Reston*

General Practice

Aaronson, Stuart Alan, *Great Falls*
Abesa, Cenon C, *Virginia Beach*
Acierto, Guillermo V, *Norfolk*
Acosta, Carlos F, *Hampton*
Adams, Hunter Doherty, *Arlington*
Adams, William B, *Richmond*
Adkins, Bruce Richard, *Weber City*
Ailsworth, Robert Dea Jr, *Keysville*
Alabanza, Tomas M, *Danville*
Albo, Cecilio Encabo, *Fredericksburg*
Alderfer, Richard D, *Radford*
Alderman, Kurtz Edward, *Clintwood*
Aldrich, Marc Nathan, *Dumfries*
Alfonso, Raymundo Palad, *Alexandria*
Allen, Benjamin Randolph, *Richmond*
Amberman, George Herbert III, *Virginia Beach*
Amrien, Donald J, *Chincoteague*
Anderson, Scott Virden, *Manassas*
Angeles, Jose Delos, *Portsmouth*
Apakupakul, Nakorn, *Windsor*
Archer, Edward R, *Norfolk*
Arias, Porfirio, *Vienna*
Arnold, Lillian Hunt, *Arlington*
Arnold, Sidney R, *Amherst*
Ashby, Charles C, *Dinwiddie*
Ashby, Samuel Kermit, *Newport News*
Ayers, Gilmer C, *Waynesboro*
Bailey, Robert Rives, *Yorktown*
Baker, Wallace Edgar, *White Marsh*
Bala, Meena E, *Chester*
Baltuch, Leigh, *Norfolk*
Bane, Earle M, *Lawrenceville*
Barclay, Charles O Jr, *Portsmouth*
Bardin, Robert Malcolm, *South Boston*
Barnes, David Wright, *Lynchburg*
Barone, Gary Wickens, *Charlottesville*
Bartley, Cavitt K, *Roanoke*
Bartley, Homer, *Roanoke*
Barton, Charles Robert Jr, *Scottsville*
Bartram, Scott F, *Falls Church*
Bassig, Ricardo A, *Fredericksburg*
Baugh, Thomas A, *Petersburg*
Bear, Joseph Wolfe Jr, *Roanoke*
Beatley, Robert Eugene, *Burgess*
Beaton, James Duncan, *Danville*

General Practice *(cont'd)*

Bedell, Kevin Robert, *Williamsburg*
Bell, Baxter Israel Jr, *Williamsburg*
Benda, Rudolf, *Austinville*
Benham, Claude, *Chesapeake*
Bennett, Lansing Heppe, *Reston*
Berger, Bruce C, *South Hill*
Bernhart, Wesley C, *Fairfax*
Berry, Bradley D, *Grundy*
Billingsley, Thaine E, *Monterey*
Bing, John P, *Stanleytown*
Bishop, William Branch, *Lawrenceville*
Blake, Michael Clarence, *Chester*
Blake, William, *Reston*
Blayton, James Blaine, *Williamsburg*
Bliss, Reba N Gwyneth, *Norfolk*
Boatwright, Charles Lee, *Blacksburg*
Boatwright, John Charles, *Roanoke*
Bohrer, Charles A, *Alexandria*
Bomberger, Karen Ann, *Lynchburg*
Bond, Glen Morris, *Gretna*
Bond, Lester R, *Gretna*
Borillo, Romeo Bisquera, *Pearisburg*
Bosworth, E W, *Onancock*
Bowers, Russell V, *Richmond*
Bowles, James H, *Sandy Hook*
Bowles, Richard Boxley, *Mathews*
Boyd, James Horace, *Virginia Beach*
Bradley, Robert W, *Powhatan*
Brandon, Brent D, *Natural Bridge*
Brandt, Kurt Theodore, *Oakton*
Brehmer, Charles Edward, *Richmond*
Brickhouse, Albert T, *Hopewell*
Bridgforth, Lewis William, *Victoria*
Brock, Macon Foscue, *Norfolk*
Brown, Esther C, *Salem*
Brown, Theodore Coots, *Richmond*
Bruch, Frederick R Jr, *Virginia Beach*
Brush, Edward V Jr, *Lexington*
Bruther, Lawrence James, *Oakton*
Bryan, Curtis Russel, *Charlottesville*
Buchanan, Robert James, *Chesapeake*
Bui, My Quang, *Falls Church*
Bull, Douglas Middleton, *Charlottesville*
Burrell, Thomas, *Falls Church*
Byrne, Joseph T, *Richmond*
Campbell, Hawes III, *Yorktown*
Campbell, John White, *Brookneal*
Campbell, Kevin Michael, *Chester*
Candler, Paul Kiser, *Virginia Beach*
Cao, Son Xuan, *Midlothian*
Capalad, Elpidio Fajardo, *Norton*
Caplan, Julius, *Portsmouth*
Carey, Edward Daniel, *Nellysford*
Carr, Quinton O, *Staunton*
Carter, Gregory P, *Newport News*
Carter, Samuel H, *Fort Defiance*
Cate, L Huntley, *Brightwood*
Chalkley, Matilda D, *Richmond*
Chappell, George Edward, *Halifax*
Cheung, Danielle Kwee, *McLean*
Childrey, Stephen, *Chase City*
Chow, Chak Lam, *Luray*
Chu, Chee Kong, *Salem*
Clague, Allen Manville, *Salem*
Claterbaugh, Raymond L, *Clifton Forge*
Clayton, Anita Louise, *Gordonsville*
Coleman, Ashby, *Altavista*
Collier, John E, *Richmond*
Conkwright, Douglas D Jr, *Virginia Beach*
Coogan, E A, *Annandale*
Cook, Kathleen Yauss, *Richmond*
Cooper, Claude E, *Falls Church*
Coppedge, Charles William, *Farmville*
Cowling, Lawrence Stanley, *Newport News*
Cox, Virgil Jefferson, *Galax*
Craig, Cedric, *Pound*
Crain, Michael, *Arlington*
Cross, James Allerton, *St Paul*
Cross, Phyllis De Carlo, *Falls Church*
Crossland, Clem C Jr, *Suffolk*
Csatary, Laszlo K, *Alexandria*
Cullen, Robert H, *Wise*
Cummins, Morag F, *Blacksburg*
Cunningham, William Scott, *Richmond*
Curry, John Lamar, *Falls Church*
Curwen, Geoffrey W, *Fieldale*
Dajao, Rise Faith, *Chesapeake*
Dajao, Rogaciano M Jr, *Portsmouth*
Daniel, Evelyn P, *Louisa*
Daniel, Griffith B, *Richmond*
Daniels, John Raymond, *Arlington*
Daughtrey, Walter F Jr, *Courtland*
David, Joseph, *Hampton*
Davies, Thomas Clifford, *Farmville*
Davis, Charles S, *Drakes Branch*
Davis, Leonard L Jr, *Portsmouth*
Davis, Thomas Philip, *Christiansburg*
Davis, William Alvin, *St Paul*
Delap, Lyle E, *Narrows*
De Las Alas, Reuben Maranan, *Richlands*
Delaura, Frank A, *Norfolk*
Desjardins, Richard Fernand, *Blacksburg*
Devaney, Kenneth Owen, *Arlington*
Dewalt, Chester W Jr, *Virginia Beach*
Di Giovanni, Cleto Jr, *Reston*
Dixon, Cecil B, *South Boston*
Doman, Mark Richard, *Virginia Beach*
Dossola, Jose M, *Alexandria*
Dougherty, Clyde Hudson, *Hopewell*
Douglas, Cromwell C, *Norfolk*
Dudley, Frank Humbert, *Gladehill*
Dunn, J Wayland, *Charlotte Courthouse*
Dyer, Raymond Douglas, *Blacksburg*
Early, Joseph H Jr, *Hillsville*
Eastham, Edwin M, *Front Royal*
Eastham, Edwin M Jr, *Front Royal*
Eddine, F S, *Falls Church*
Edmunds, Elizabeth Holt, *Lynchburg*
Elliott, James William, *Lebanon*
Elliott, Patricia L, *Rapidan*
Ellis, William Joseph, *Covington*
Ellison, Oscar III, *Falls Church*
Eppes, Edward M III, *Lancaster*
Escalante, Guido R, *Norfolk*
Eshleman, Merle W, *Harrisonburg*
Eskridge, Walter A, *Parksley*
Espina-Dajao, Rise F, *Portsmouth*
Esteban, Granwel A, *Hurley*
Evans, Cecil F, *Newport News*
Farano, Louis III, *Virginia Beach*
Farley, William John, *Norfolk*
Faulconer, Jack Sterling, *Madison Heights*
Fehr, Gregory Brien, *Hampton*
Felton, Harold William, *Deltaville*
Ferlazzo, Alfred J, *Dumfries*
Field, Burton Eugene, *Dillwyn*
Fisher, Paul Lloyd, *Tappahannock*
Flores, Rosario M, *Richmond*
Foelsche, Ruth, *Yorktown*
Forbes, John William III, *Stuarts Draft*
Ford, Michael B, *Big Stone Gap*
Forrester, William M T, *Richmond*
Foster, William Leicester, *Roanoke*
Fox, Kurt J, *Fairfield*
Fralin, G Wayne, *Roanoke*
Francisco, Reynaldo M, *Virginia Beach*
Frazier, John Richard, *Salem*
Freedman, Irwin Stanley, *Alexandria*
Frenkel, David S, *Falls Church*
Friesen, Clifford David, *Staunton*
Gamble, James H, *Lovingston*
Gannon, James A, *Upperville*
Garcia, Pablo B, *Richmond*
Garratt, Bruce Thomas, *Suffolk*
Gaylord, Charles F, *Staunton*
Gharagozloo, Mohamad A, *Alexandria*
Gharse, Suresh P, *Richmond*
Gill, Fleming W, *Richmond*
Gill, James T, *Ashland*
Givens, Julian Lee, *Independence*
Givens, Paul Brown Jr, *Newport News*
Gladstone, Joseph E, *Exmore*
Glick, John T Jr, *Broadway*
Glover, William P, *Virginia Beach*
Godwin, Gene A, *Salem*
Goldman, Milton S, *Chesapeake*
Gondor, Leslie Paul, *Alexandria*
Gondos, Zoltan III, *Arlington*
Gonzales, George Tendero, *Fredericksburg*
Goodman, Benjamin M Jr, *Franklin*
Gotico, Rustico T, *Williamsburg*
Graham, Ota T Jr, *Richmond*
Graves, Asa Wesley V, *Lacey Spring*
Graybeal, Henry Charlton, *Christiansburg*
Green, Walter Franklin III, *Harrisonburg*
Greenhalgh, John Smith, *Dumfries*
Greer, William Crockett, *Roanoke*
Gregoriou, Panos George, *Clintwood*
Grether, Eugene Rudolf, *Alexandria*
Guanzon, Cesar Sancha, *Danville*
Guanzon, Raphael F, *Portsmouth*
Guardia, Ricardo, *Newport News*
Guieb, Adelaida, *Manassas*
Haddock, Edward Ellis, *Richmond*
Hakim, Fehmi, *Vienna*
Halmai, Zoltan, *Portsmouth*
Ham, T, *Vienna*
Hambaz, Nasser, *Virginia Beach*
Hancock, William Cary, *Richmond*
Hanna, Howard Michael Jr, *Fort Defiance*
Hargrove, Brooks L Jr, *Portsmouth*
Harmon, Anthony Garfield, *Farmville*
Harris, Alan Craig, *Richmond*
Harris, Edward D, *Virginia Beach*
Harris, James Selden, *Blackstone*
Harrison, Henry Tucker Jr, *Midlothian*
Hart, William, *Falls Church*
Harwood, Charles Pinchbeck, *Sandston*
Hatfield, Cecil C, *Saltville*
Hearn, John T, *Penn Laird*
Heda, Tibor, *Petersburg*
Henderson, Edmund M, *Nassawadox*

General Practice *(cont'd)*

Herbrandson, Clarence Roger, *Forest*
Hermann, Ernest Conrad, *Richmond*
Higgs, James Albert, *Staunton*
Hladys, Jacob J, *Richmond*
Ho, Hien Van, *Falls Church*
Hoback, Daniel Pflum, *Roanoke*
Holden, Bobby G, *Petersburg*
Holladay, Beverly L, *Suffolk*
Holland, Clarence Adrian, *Virginia Beach*
Hosfield, William Howard, *West Point*
Hotchkiss, William J, *Broadway*
Howard, Farrar W, *Providence Forge*
Hubbard, Benjamin Arthur Jr, *Virginia Beach*
Hudgins, Hubert Bland, *Mathews*
Hughes, Robert C, *Roanoke*
Hughes, William C, *Boones Mill*
Hunter, Edward Sidney Jr, *Virginia Beach*
Hurt, Charles W, *Charlottesville*
Hussain, Mohammad Belayet, *Portsmouth*
Huynh, Luong Quang, *Annandale*
Hylton, Claude K, *Manassas*
Hylton, James Moir, *Pulaski*
Iden, Robert William, *Warrenton*
Irby, Jethro Hurt, *Martinsville*
Irvin, Emory R, *Galax*
Jacklin, Lawrence A, *Falls Church*
Jackson, John A, *Portsmouth*
Janis, Leo B, *Virginia Beach*
Jean, Cheo-Ming, *Annandale*
Jenkins, Charles E, *Alexandria*
Jennings, W Stanley, *Chesapeake*
Johnson, Frank Mitchell, *Roanoke*
Johnson, James B, *Ewing*
Johnson, Warren E, *Purcellville*
Johnson, William Thomas, *Virginia Beach*
Johnston, Mary E, *Tazewell*
Jones, Edward A, *McLean*
Jones, Elizabeth Lucille, *Buckingham*
Jones, Joseph L, *Williamsburg*
Jones, Lawrence D, *Lynchburg*
Joyner, Raymond Kenneth, *Yorktown*
Juguilon, Bernardino T, *Portsmouth*
Julius, Aristides D, *Richmond*
Kapur, Manohar Lal, *Suffolk*
Karow, Juliette Seelye, *Williamsburg*
Kauffman, Stephen Charles, *Alexandria*
Keeling, Robert D, *South Hill*
Keilman, David A, *Roanoke*
Kendrick, Marvin H, *Alexandria*
Kent, James Carl, *Woodbridge*
Kerpelman, Earle Jerome, *Virginia Beach*
Kerr, Horace E, *Colonial Beach*
Kessler, Chester William, *Annandale*
Ketron, Samuel Gilmer, *Lebanon*
Kimbrough, Janet Coleman, *Williamsburg*
Kirkland, James A Jr, *Emporia*
Kosmahly, Gerhard, *Mineral*
Kramer, Dan, *Fairfax*
Kudirka, Vincentas, *Blackstone*
Kuhn, Amy Louise, *Manassas*
Kuzma, Benjamin B, *Arlington*
Laibstain, Alter, *Virginia Beach*
Lamberth, Melvin B Jr, *Kilmarnock*
Langille, David Keith Crosby, *Virginia Beach*
Laster, James, *Falls Church*
Lazarini-Lugo, Jose Antonio, *Woodbridge*
Leary, John Edward, *Warrenton*
Lee, David Donghan, *Fairfax*
Lee, Young, *Petersburg*
Lemeshewsky, George P, *Alexandria*
Leming, Joseph A, *Waverly*
Leonard, Gordon K, *Amherst*
Lerner, Martin, *Norfolk*
Lewis, Kerry Randall, *Fairfax*
Lindsay, Frank G Jr, *Portsmouth*
Litchfield, John Thomas Jr, *Kilmarnock*
Litton, Frederick M, *Big Stone Gap*
Livingood, J K, *Herndon*
Long, George E, *Fairfax*
Longest, Donald Benson, *Mechanicsville*
Longford, D J, *Smithfield*
Lowe, Luther Burton, *Roanoke*
Luttrell, Homer B, *Pulaski*
Lynch, James Michael, *Chantilly*
Lynch, Vernon Lee II, *Rocky Mount*
Lyon, Everett C Jr, *Gainesville*
Mac Millan, Ralph V, *Richmond*
Mackintosh, Robert A, *Annandale*
Mann, H Thompson, *Richmond*
Marshall, Lawrence Vinton, *Floyd*
Martin, Jerry Wayne, *Washington*
Martin, John Oliver, *Fairfax*
Martin, Lee B, *Arlington*
Martin, Lee Baldwin Jr, *Arlington*
Mason, Mark S, *Manassas*
Massie, George B, *Catharpin*
Massie, Samuel Powell, *Stuart*
Mathews, J Lee Jr, *Manassas*
Matthews, Cornelius F, *Martinsville*
May, Madge D, *Nassawadox*
Mc Bride, Dane C, *Roanoke*
Mc Cabe, William Otey, *Forest*
Mc Cahill, Thomas D, *Mechanicsville*
Mc Clung, John Houston, *Glasgow*
Mc Clung, Oscar H Jr, *Lexington*
Mc Collum, W D, *Richmond*
Mc Cown, John G, *Roanoke*
Mc Glade, Rose Marie, *Richmond*
Mc Guire, Joseph F, *Pearisburg*
Mc Neely, Irwin Hollar, *Franklin*
Melchionna, Olin Richard, *Roanoke*
Melih, E, *Norfolk*
Melton, Harvey Edward, *Winchester*
Meza, Rene S, *Arlington*
Micou, Lewis A, *Virginia Beach*
Miller, Charles S, *Elkton*
Miller, Stage Edmund, *Edinburg*
Minarik, Harry J, *Salem*
Mitchell, Arthur V, *Arlington*
Mizzi, Alexander, *Staunton*
Moody, William Edward, *Scottsville*
Moore, Chimer Davis Jr, *Wytheville*
Moore, Dorothy Diehl, *Petersburg*
Moore, Ernest Eugene, *Richlands*
Moore, Harry Lynn Jr, *Mint Spring*
Moore, Kermit J, *Petersburg*
Morris, Douglas C, *Warrenton*
Morse, Jeffrey Hale, *Virginia Beach*
Motley, Virgil Atwell, *Abingdon*
Motos, Ramon A, *Richlands*
Mundy, Charles B, *King George*
Myers, Donald S, *Hot Springs*
Myers, John Baggarly, *Chesapeake*
Nafzinger, Moses Le Roy, *Woodbridge*
Nakanishi, Junichiro Luke, *Virginia Beach*
Nandipati, Sailaja Charagundla, *Burke*
Napolitano, Stephen J, *Leesburg*
Naurath, Rudolph Joseph, *Newport News*
Neale, Milton M Jr, *Heathsville*
Neisser, Herbert H, *Newport News*
Ngo, Thuan Dinh, *Arlington*
Nguyen, Tien Duc, *Midlothian*
Nicholson, M Roy, *Arlington*
Nicklin, Walter S Jr, *Warrenton*
Niner, Paula Jo, *Newport News*
Noble, Estrellita Bugayong, *Williamsburg*
Norris, William T Jr, *Salem*
O'Brien, Clyde G, *Appomattox*
O'Brien, David C, *Portsmouth*
Ochoa, Virgilio V, *Colonial Heights*
Odend'Hal, Fortune, *Remington*
Odiaga, Carlos E, *Annandale*
Oglesby, F Elliott Sr, *Richmond*
Oliver, Keith Millner, *Purcellville*
Oneill, Dennis M, *Newport News*
Orr, Robert Alden, *Leesburg*
Orr, William King, *Fishersville*
Orsinger, William Hubert, *Arlington*
Otto, Wayne Rupert, *Fairfax*
Owens, Beryl Henry, *Rose Hill*
Paine, Wilmer H, *Charlottesville*
Painter, William G, *Fort Defiance*
Palmer, Alfred Monroe, *Falls Church*
Parker, Donal S, *Tabb*
Pauliukonis, Kestutis J, *Annandale*
Peck, Joseph C, *Galax*
Pedersen, Paul D, *Oakton*
Peerless, Julius, *Annandale*
Pennington, William Alton, *Buckingham*
Phan, Vy Van, *Fairfax*
Phillips, Lawrence Vince, *Round Hill*
Phlegar, David Shanks, *Blacksburg*
Pho, Van Ngoc, *Falls Church*
Picou, Wally John, *Virginia Beach*
Pla, Maria Eugenia-Rita, *Ft Eustis*
Pleasants, Alfred W Jr, *Lexington*
Pollard, William B Jr, *Charlottesville*
Pope, Thomas B, *Petersburg*
Pope, William Barrett Jr, *Portsmouth*
Porter, Jesse J, *Appalachia*
Potts, James Michael, *Virginia Beach*
Powe, Walker H Jr, *Blacksburg*
Powell, Alfred E, *Madison*
Powell, Stanley H, *Portsmouth*
Powell, Unity M, *Covington*
Price, Homer H, *Martinsville*
Price, Ralph, *Newport News*
Prince, John Stuart, *Emporia*
Prinz, Werner, *Falls Church*
Pulizzi, John S Jr, *Alexandria*
Pulizzi, John S Sr, *Alexandria*
Quaintance, R W Jr, *Culpeper*
Quarles, Joseph James Jr, *Norfolk*
Rada, Dini Hartono, *Blacksburg*
Ramachandriah, Anjankumari M, *Forest*
Ramolia, Mansukhlal R, *Chesapeake*
Ramsey, Oscar L Jr, *Lynchburg*
Rana, Izhar Ahmed, *Pocahontas*
Randall, Eugene Henry, *Martinsville*
Randolph, David Marcus, *Richmond*
Rangel, Jorge Garcia, *Fairfax*

General Practice *(cont'd)*

Ransone, Sterling Neblett, *Mathews*
Ratliffe, Norman C, *Clintwood*
Ray, Catherine T, *Richmond*
Reardon, William John, *Falls Church*
Recio, Alfredo Hernandez, *Fairfax*
Redding, Gorman Joseph, *Alexandria*
Reddy, Patlolla V, *Wise*
Reed, H Toney, *Mathews*
Reed, Richard C, *North*
Reese, Emmett F III, *Courtland*
Reid, Lonnie T, *Suffolk*
Reid, Margaret W, *Suffolk*
Reish, William Edwin, *Harrisonburg*
Reuwer, John Francis, *Radford*
Rhee, Kyung Uk, *Virginia Beach*
Rice, David B, *Fredericksburg*
Richards, Charles Jr, *Richmond*
Richardson, Emmett V Jr, *Marion*
Riggins, William M Jr, *Lynchburg*
Robbins, William Lacy Jr, *Martinsville*
Roberts, John Edmund, *Alexandria*
Robertson, Jesse D, *Staunton*
Robeson, Ella P Tompkins, *Hampton*
Robinette, David E, *Fairfax*
Robinson, William Mayer, *Richmond*
Robson, Scott M, *Alexandria*
Rodgers, Allan Flexner, *Alexandria*
Rodriguez, Claudio Jr, *Norfolk*
Rogacz, Suzanne, *Annandale*
Rogers, Lynette Sylvia, *Virginia Beach*
Rose, John B Jr, *Fredericksburg*
Rosenberg, Maurice S, *Williamsburg*
Rosner, Edmond, *Colonial Beach*
Ross, William Woodrow, *Newport News*
Royal, Frank Spencer, *Richmond*
Royer, Thomas C, *Norfolk*
Rucker, William Vincent, *Bedford*
Rudnikas, Isaac, *Falls Church*
Ruffin, Herbert G, *Richmond*
Rutkoski, Ignatius, *Arlington*
Sadighian, Z Dean, *South Hill*
Sadler, William Anderson, *Mathews*
Salazar, Angel E, *Burr Hill*
Sanner, Marvin Q, *Alexandria*
Saunders, Thomas Archer, *South Hill*
Sayed, Hamdy I, *Richmond*
Schechner, Joseph, *Norfolk*
Schellenberg, Paul H, *Gainesville*
Schiffert, Charles Wilson, *Blacksburg*
Schmidt, Edmund Julian, *Blacksburg*
Scott, Paul Anderson, *Chincoteague*
Scouras, George P, *Martinsville*
Seibert, John Douglas, *Chesapeake*
Shaffer, John Scott, *Abingdon*
Sharma, Sunil, *Burke*
Sheehy, Stephen Joseph, *Arlington*
Shelton, William A, *Boydton*
Sherman, Elizabeth B, *Front Royal*
Shin, Kun Suck, *Alexandria*
Shull, Owen C, *Herndon*
Singh, Chand, *Roanoke*
Singh, Ram, *Norton*
Sisson, Harold Edward, *Warsaw*
Sizer, Kenneth B, *Danville*
Skewes, David Jessop, *Dublin*
Smith, J Earle, *Richmond*
Smith, James H, *Christiansburg*
Smith, Joseph John, *Hampton*
Smith, Joseph Paul, *Chesapeake*
Smith, Robert D Jr, *Norton*
Smith, Russell, *Piney River*
Smith, Samuel N, *Roanoke*
Smith, Thomas E, *Norfolk*
Snead, Howard Garnett, *Stephens City*
Snead, Russell N, *Columbia*
Solet, Leo, *Arlington*
Solinap, Daniel T, *Norfolk*
Somers, Lewis Frank, *Lynchburg*
Sowers, Richard P, *Richmond*
St George, John R, *Portsmouth*
Staehr, Patricia Ann, *Virginia Beach*
Stark, Carl E, *Wytheville*
Steele, R F Jr, *Petersburg*
Stenicka, Francis J, *Chesapeake*
Stephens, Mary-Louise, *Front Royal*
Stoll, Edward J, *Lynchburg*
Stone, Gail R, *Radford*
Stout, William H, *Hopewell*
Strasser, Heinz J, *Crozet*
Suslick, Randall Hugh, *Chase City*
Sutherland, Joann J, *Swoope*
Sutherland, Joshua P, *Grundy*
Tamariz, Theodore E, *Alexandria*
Tandy, Marlene Karen, *Arlington*
Taylor, Francis N, *Petersburg*
Taylor, Kelley Darrell II, *Pennington Gap*
Tessitore, Andrew, *Fairfax*
Tharp, Arvel Dwayne, *Fairfax*
Thatcher, Joseph O M, *Virginia Beach*
Thigpen, Calvin H, *Petersburg*
Thomas, John H Jr, *Greenville*
Thomas, Philip R, *Suffolk*
Thompson, Charles G, *Marion*
Thompson, Girard V Jr, *Chatham*
Thompson, Stephen Lee, *Rustburg*
Towe, James L, *Purcellville*
Travis, Thomas R, *Montross*
Treakle, Kevin Burke, *Lawrenceville*
Trice, Robert Palmer, *Richmond*
Troxel, George E, *Winchester*
Tucker, Billy Jack, *Chesapeake*
Tuggle, M Stuart W, *Keysville*
Tyler, John Hutchinson, *Chester*
Upton, Leslie, *Alexandria*
Van Der Sommen, Lynda D, *Louisa*
Van Der Spuy, Benjamin H, *Hampton*
Van Driem, George H, *Toano*
Van Name, Arthur L Jr, *Urbanna*
Vanover, Patricia H, *Clintwood*
Varese, Yonne D, *Newbern*
Vargas, Honesto B, *Portsmouth*
Victor, Fenn, *Roanoke*
Villavicencio, Jorge E, *Fairfax*
Vitarello, John Pascal, *Fredericksburg*
Vlahcevic, Zdravko Reno, *Richmond*
Vlahos, Michael M, *Sterling*
Voshell, Thomas Hammersley Jr, *Virginia Beach*
Waddill, James Thomas III, *Chester*
Walker, Thomas Andrew, *Emporia*
Walker, Walter J Jr, *Radford*
Walthall, David B III, *Arlington*
Wampler, Garland J, *Staunton*
Ward, Oscar Wilde Jr, *Hampton*
Warden, William Budd, *Virginia Beach*
Ware, Earle Rawlings, *Fredericksburg*
Wasti, S F, *Richmond*
Waterman, George Richard, *Woodstock*
Watson, T Le Pierre, *Cartersville*
Weaver, Tureman G, *Richmond*
Weinstein, David Jay, *Wakefield*
Wember, David Gerald, *Falls Church*
White, J A, *Virginia Beach*
Whitmore, William Harvey Jr, *Norfolk*
Whitworth, F Dixon, *Front Royal*
Wilkinson, George Lee, *South Boston*
Williams, Charles Lee, *Richmond*
Williams, David C, *Richmond*
Williams, Mark Byrd, *Petersburg*
Williams-Mcdonald, Ann H, *Virginia Beach*
Willis, Hugh H Jr, *Chatham*
Wilson, Mary Stuart, *Keysville*
Winkfield, James M, *Strasburg*
Wisotsky, Herbert, *Fairfax*
Wolfsohn, Alice, *Arlington*
Wolfson, Aaron Howard, *Richmond*
Wray, Frank Grove, *South Boston*
Wysor, Edwin Snead, *Mechanicsville*
Yerby, Phillip C III, *Hopewell*
Yoon, Heung-Lho, *Great Falls*
York, James R, *Berryville*
Youngblood, Walker P, *Hopewell*
Yunas, Mohammad, *Portsmouth*
Zieve, Sandra L, *Midlothian*
Zolkiwsky, Walter R, *Sterling*

General Preventive Medicine

Albertson, Anna Jane, *Alexandria*
Arnoldi, Louis B, *Alexandria*
Bennett, Bruce H, *Dumfries*
Bilbra Nelson, Linda J, *Roanoke*
Boaz, Thurmond D Jr, *McLean*
Borcherding, Donald L, *McLean*
Bornmann, Robert Clare, *Reston*
Cho, Byoung Suen, *McLean*
Churchill, Frank Edward Jr, *Richmond*
Clarke, Eugene Joseph Jr, *Roanoke*
Clinton, John Jarrett Jr, *Herndon*
Costin, Ronald Elton, *Arlington*
Di Benedetto, Margarete, *Ft Monroe*
Duley, Robert K, *Richmond*
Fernandes, Victoria Florence, *Salem*
Foulke, John David, *Fairfax Station*
Gates, Francis Kenneth Jr, *Kilmarnock*
Gayle, Seth Jr, *Richmond*
Gillespie, Harold E, *Richmond*
Ha, Chang Young, *Richmond*
Hansen, Richard Donald, *Hayes*
Hark, William Henry, *Alexandria*
Huddleston, Charles Louis II, *Virginia Beach*
Hunt, Patricia A, *Richmond*
Ireland, Roger Gordon, *Woodbridge*
James, James Januarius, *Fairfax Station*
Kegley, James B Jr, *Bristol*
Kendra, Stephen John, *Virginia Beach*
Kenley, James B, *Richmond*
Kinneman, Robert Eugene Jr, *Culpeper*
Krank, Daniel Frederick, *Reston*
Lebrun, Andre Joseph, *McLean*
Liberson, Wladimir Theodore, *Norfolk*

General Preventive Medicine *(cont'd)*

Maccorquodale, Donald Willard, *Petersburg*
Marcelino, Victoria Flores, *Richmond*
Mathew, Mammen Mathai, *Charlottesville*
Mc Keogh, Robert Paul, *Williamsburg*
Mc Leod, Susan L, *Charlottesville*
Miller, Richard K, *Fairfax*
Moon, Agnes Hyungnam, *Norfolk*
Moore, George, *White Stone*
Nicogossian, Arnauld E, *Fairfax*
Nottingham, Stuart C, *Alexandria*
Officer, Thomas Patrick, *Arlington*
Palmer, James David Keith, *Hampton*
Payne, Fred J, *Herndon*
Peterson, Kent W, *Charlottesville*
Pollard, Joseph Page, *Arlington*
Price, Dudley Randolph, *Stanley*
Prindle, Richard A, *Charlottesville*
Pruett, Carl E, *McLean*
Quinnell, Robert Kay, *Kilmarnock*
Rowe, Theodore C III, *Portsmouth*
Sacmari, Gabriele, *Richmond*
Sayvetz, Tom Andrew, *Ashland*
Seeley, Richard John, *Virginia Beach*
Shamburek, Roland H, *Annandale*
Sharrett, Carol S, *Arlington*
Singer, Janet Moorfield, *Arlington*
Smith, Catherine H, *Fairfax*
Sowder, Wilson Thomas, *Ferrum*
Stevick, Charles Paul, *Newport News*
Stone, George Martin II, *Portsmouth*
Swanson, Dennis Ray, *Danville*
Tempkin, Alan Robert, *Roanoke*
Tierney, Clementine H, *Arlington*
Vasquez, Blesila Reyes/Angeles, *Richmond*
Warren, Daniel C, *Gloucester*
Wood, Robert Lannes, *Mechanicsville*
Wright, Diana Dryer, *McLean*

General Surgery

Aaron, Benjamin L, *Arlington*
Acra, Wadi De Jesus, *Norfolk*
Adams, Elizabeth Granger, *Arlington*
Adams, Reid Barton, *Charlottesville*
Adeson, Robert Lawrence, *Alexandria*
Adler, Theodore, *Virginia Beach*
Adrales, Mamerto, *Covington*
Akrout, Jamel Eddine, *McLean*
Al-Mahayiri, Abdullah, *Alexandria*
Albright, Victor F, *Winchester*
Albuerne, Humberto M, *Burke*
Alegria, Fernando, *Fairfax*
Allen, Miller Shannon Jr, *Charlottesville*
Alrich, Elton Meredith, *Charlottesville*
Alty, Charles Gregory, *Richmond*
Amarasinghe, D C, *Virginia Beach*
Amole, Charles Varner, *Petersburg*
Amparan, Aquiles, *Bedford*
Ancheta, Romulo Andres, *Luray*
Andrew, Theodore C, *Hopewell*
Anez, Osvaldo C, *Vienna*
Antonio, Eugenio V III, *Hopewell*
Archer, Harry Lee, *Charlottesville*
Arcomano, Todd Richard, *Arlington*
Armbrister, Douglas K, *Marion*
Ashworth, John W, *Emory*
Askew, Allyson Ann, *Annandale*
Asrani, U F, *Blacksburg*
Ayyildiz, Vedii Jr, *Salem*
Bacaner, Tobias Jay, *Charlottesville*
Bacchetta, Carlos Antonio, *Charlottesville*
Bafi, Ammar S, *McLean*
Bailey, Andrew Allison Jr, *Charlottesville*
Bajwa, Gurnam S, *South Boston*
Baker, James Pray, *Warrenton*
Baker, John William Jr, *Norfolk*
Baker, Joseph Wilmler, *Covesville*
Banchuin, Thongdang, *Wise*
Banner, Robert L, *Richmond*
Barakey, Amiele, *Chesapeake*
Bardakjian, Vatche Barkev, *Charlottesville*
Baron, Paul Lawrence, *Richmond*
Barrett, Christine E, *Rocky Mount*
Barsanti, Christopher Michael, *Earlysville*
Bartlett, Donald E Jr, *Roanoke*
Beach, Leslie Myatt, *South Boston*
Beargie, Richard J, *Fairfax*
Beasley, Walter Ewing III, *Virginia Beach*
Beazley, Wyatt S III, *Richmond*
Bechamps, Gerald Joseph, *Winchester*
Belandres, Manuel M, *Stafford*
Bell, C Cooper Jr, *Newport News*
Bell, Rudolph Mardre, *Staunton*
Bell, William Robert, *South Boston*
Belle, Walton M, *Richmond*
Bengtson, Keith Allen, *Manassas*
Benton, Gary Stephen, *Chester*
Beranek, Steven R, *Ft Lee*
Berger, James Seymour, *Virginia Beach*
Berghuis, Jacob, *Dutton*
Berman, Scott Steven, *Virginia Beach*
Berry, H Lee, *McLean*
Berry, Robert Edward, *Roanoke*
Berry, Thomas K, *Martinsville*
Bhasin, Ram Pal, *Bluefield*
Bhat, Inder K, *Arlington*
Biddulph, John Thomas, *Norfolk*
Blanchard, Peter B, *Virginia Beach*
Blanchet, Nadia P, *Richmond*
Blase, William P, *McLean*
Bogdonoff, David Leonard, *Charlottesville*
Boggs, Charles Harmon Jr, *Salem*
Bokinsky, Gary Brooks, *Richmond*
Boman, Thomas Edward, *Charlottesville*
Bono, Joseph Albert, *Roanoke*
Bono, Raquel Cruz, *Norfolk*
Boone, Owen Riley, *Leesburg*
Bowden, Lemuel, *Virginia Beach*
Boyd, Robert S, *Winchester*
Boyer, A Stephen, *Nassawadox*
Boykin, Joseph V Jr, *Midlothian*
Brewer, Richard James, *Charlottesville*
Brewer, Robert Francis, *Chesapeake*
Brewer, Robert George, *Virginia Beach*
Brickman, Robert D, *Lexington*
Britt, John Mills Jr, *Franklin*
Britt, Lunzy D, *Norfolk*
Brochu, Francis Louis, *Salem*
Broman, George Ellis, *Culpeper*
Brown, James George, *Alexandria*
Brown, Kenneth Blair, *Richmond*
Brown, Peter Wilcox, *Richmond*
Brown, Stuart Ellett III, *Berryville*
Brown, Toby L, *Warrenton*
Bryan, Phillips R, *Lynchburg*
Bryant, Alvin, *Hampton*
Bryson, Gilbert Hamilton, *Richmond*
Buchanan, Patricia Kay, *Richmond*
Buchly, Mark Lee, *Arlington*
Bunch, John Dallas III, *Warrenton*
Burger, Ray Edward Jr, *Nassawadox*
Burk, Lloyd B Jr, *Locust Grove*
Burns, Peter Francis, *Richmond*
Burt, Joe Howard, *Virginia Beach*
Bushman, Wade Alan, *Charlottesville*
Butkiewicz, John V, *Hampton*
Buxton, Russell V, *Newport News*
Byrd, Charles W, *Richmond*
Cabiling, Marino M, *Manakin Sabot*
Cain, Arthur S Jr, *Williamsburg*
Calilung, Cesar S, *Narrows*
Camp, Thomas F Jr, *Alexandria*
Campbell, Robert M, *Chesapeake*
Canadas, Antonio L, *Arlington*
Canizares, Roberto R, *Fredericksburg*
Capati, Bienvenido Balingil, *Franklin*
Caplan, Robert B, *Portsmouth*
Cardenas, Francisco III, *Arlington*
Carmichael, Paul A, *Roanoke*
Carter, B Noland II, *Richmond*
Carter, Russell H, *Norfolk*
Carwell, Glenn Ray Jr, *Virginia Beach*
Caulkins, Charles W Jr, *Waynesboro*
Caulkins, David Whitney, *Waynesboro*
Cay, Emine, *Fairfax*
Cazan, Matthew John, *Falls Church*
Ceballos, Rodolfo B, *Marion*
Cecil, William B Jr, *Pearisburg*
Chakravorty, Ranes C, *Salem*
Chalkley, Milton De Rohan, *Suffolk*
Chan, Barry B K, *Charlottesville*
Chan, Yung C, *Pulaski*
Chang, Dillon Ernest, *Fairfax*
Chang, Jonathan Lee, *Charlottesville*
Charles, Michael George, *Newport News*
Chaudhuri, Mohan L, *Chesapeake*
Chavis, Timothy V, *Radford*
Cheung, Dominic Kui Kong, *Newport News*
Cho, Kyoung S, *Roanoke*
Chohany, George J, *Williamsburg*
Christie, Anastasia Mary, *Charlottesville*
Christie, Laurence Glenn, *Richmond*
Chua, Leong Yap, *Alexandria*
Cimochowski, George E, *Staunton*
Clark, Andrew Stone, *Richmond*
Clarke, John Palmore, *Virginia Beach*
Clarke, Norma Veronica, *Richmond*
Clary, Richard M, *Richmond*
Claustro, Joseph Carino, *Richlands*
Clough, Lewis R, *Salem*
Cohen, Alan Brent, *Hampton*
Coin, Richard E, *Portsmouth*
Coleman, Custis Lansing, *Richmond*
Coll, Jose D, *Richmond*
Collins, Michael F, *Springfield*
Collmann, Warren X, *Farmville*
Conerly, James Michael, *Roanoke*
Conquest, H Fairfax, *Richmond*
Conrad, Peter Walter, *Arlington*
Conti, Eugene Carlo, *Virginia Beach*
Corcoran, David B, *Suffolk*

General Surgery *(cont'd)*

Courtney, C B Jr, *Newport News*
Cox, Philip A, *Fredericksburg*
Coxe, Joseph Wentworth III, *Richmond*
Crawford, Andrea Bach, *Gloucester*
Crawford, Harry S Jr, *Richmond*
Cross, Cecil Bernard, *Leesburg*
Cross, Gregory H, *Portsmouth*
Cross, John Armstrong, *Newport News*
Crossland, Stanley G, *Arlington*
Custer, Monford D Jr, *Winchester*
Cutter, Edgar Burford, *Roanoke*
Dahbar, Jorge Eduardo, *McLean*
D'Amato, Luciano, *Wise*
Darden, James Ryland Jr, *Richmond*
Dascombe, William Hugus, *Norfolk*
Daugherty, Stephen F, *Front Royal*
Davidson, Jesse T III, *Roanoke*
Davis, Charles Emmett Jr, *Norfolk*
Davis, Ronald Kenneth, *Richmond*
Daw, Albert Lee, *South Hill*
Dayanim, Behrooz, *Portsmouth*
Deal, William R, *Wytheville*
Debbas, Elie G, *Alexandria*
De Guzman, Cesar V, *Madison Heights*
De Haas, David R Jr, *Virginia Beach*
Deitrick, John Christopher, *Richmond*
Dekker, Jan Jacob, *Annandale*
Del Pilar, Jaime V, *Manassas*
Delaney, William Morgan, *Alexandria*
De Los Santos, Arturo F, *Woodbridge*
De Los Santos, Gregorio R, *Yorktown*
Denton, James Wayne, *Abingdon*
De Santos, Jorge T, *Virginia Beach*
Detmer, Don E, *Charlottesville*
Dettinger, Garth B, *Fairfax*
Deutsch, Alan Seth, *Alexandria*
Deyerle, Henry Price, *Harrisonburg*
Dignan, Rebecca J, *Glen Allen*
Distasio, Anthony John II, *Chesapeake*
Donato, Antonio Tuason, *Roanoke*
D'Orta, James A, *Alexandria*
Doss, Otis W, *Nassawadox*
Drake, David Bartleson, *Charlottesville*
Drake, Leearle B, *Warrenton*
Drummond, Charles Stitt Jr, *Richmond*
Dugan, Buchanan Merryman, *Edinburg*
Dunn, James Dewey, *Richmond*
Dworkin, Gary Howard, *Richmond*
Dye, Nancy Viviano, *Charlottesville*
Earley, Charles Marion Jr, *Virginia Beach*
Easley, Charles Allen Jr, *Danville*
Easterling, John G, *Charles City*
Easterly, Harry Watkey III, *Richmond*
Economo, George, *Danville*
Edge, Stephen Barrow, *Charlottesville*
Edlich, Richard F, *Charlottesville*
Edmunds, Meade C Jr, *Clifton Forge*
Edson, Ralph Howard, *Waynesboro*
Ellis, Charles M Jr, *Fort Eustis*
Ellison, Richard C Jr, *Norfolk*
Enderson, Laurence William III, *Virginia Beach*
Estrera, Clemente S Jr, *Petersburg*
Evans, Martin Terry, *Richmond*
Evans, Richard P, *Afton*
Evans, Sandidge, *Hampton*
Faize, Hossein, *Pennington Gap*
Fear, Douglass D, *Roanoke*
Feinberg, Richard L, *Arlington*
Ferguson, Wayne William, *Virginia Beach*
Fernandez, Hector O, *Hopewell*
Fidei, Francis G, *Pearisburg*
Fink, Stephen Adam, *Newport News*
Finne, Charles O Jr, *Saltville*
Fischer, Beverly Anne, *Arlington*
Fitchett, Claiborne W, *Norfolk*
Fleury, George J, *McLean*
Flynn, Charles Laurence, *Newport News*
Fogarty, Jacqueline Mary, *South Boston*
Fogle, Martin A, *Norfolk*
Fowler, Donald R, *Staunton*
Fox, Nelson Moffett, *Martinsville*
Franco, Paulo E, *Annandale*
Frank, James Leslie, *Richmond*
Frank, Robert J, *Newport News*
Frantz, David Widener, *Lynchburg*
Fraser, Kenneth William, *Arlington*
Fuller, W Allen, *South Boston*
Fuller, William Allen Jr, *South Boston*
Furman, Richard L, *Suffolk*
Gaddy, Michael Curtis, *Norfolk*
Garrett, Calvin S, *Madison Heights*
Garrett, Roland G Jr, *Newport News*
Gartside, Roberta Lee, *Reston*
Gates, Thomas Jarman, *Leesburg*
Gaunt, Hunter Marshall Jr, *Winchester*
Gayle, William E Jr, *Lynchburg*
Geib, Philip Oldham, *Portsmouth*
George, Jeffrey E, *Roanoke*
Gervin, Alfred Spencer, *Richmond*
Getz, Stanley B Jr, *Norfolk*
Gibney, Matthew Joseph III, *Burke*
Gibson, Thomas Jesse, *Winchester*
Gilbert, Carol M, *Roanoke*
Gillespie, Barnes Jr, *Newport News*
Gilliam, Linda Harris, *Fort Lee*
Gindhart, John H, *Rileyville*
Glauser, Frederick L, *Richmond*
Glickman, Marc Harris, *Norfolk*
Gloudeman, Mark B, *Alexandria*
Godsey, Ralph Edwin, *Crewe*
Gomes, Mario Nascimento N, *McLean*
Gomez, Cosme Anibal, *Annandale*
Gonzalez, Amauri Luis, *Newport News*
Gonzalez, Sandy M, *Richmond*
Gould, Randolph J, *Norfolk*
Goumas, Marcus P, *McLean*
Grace, George Thomas, *Richmond*
Graham, A Stephens, *Richmond*
Graham, Walter Hopkins, *Newport News*
Grantham, Alan Welles, *Abingdon*
Gray, Frederic Wood, *Hampton*
Greenfield, D Tyler, *Richmond*
Greenspan, Mark, *Norfolk*
Grob, Baruch Mayer, *Norfolk*
Groglio, Gregory Louis, *Vienna*
Guacena, Gonzalo F Jr, *Fredericksburg*
Guanlao, Rolando A, *Richlands*
Guerrero, Fortunato M Jr, *Dale City*
Guisto, Donald Frank, *Richmond*
Gutierrez, Leo Mendoza, *Disputanta*
Hacker, Richard Keith, *Stafford*
Hafner, Gordon Harold, *Arlington*
Hale, Douglas Alan, *Alexandria*
Hall, William B Jr, *Critz*
Hammack, Phillip Larry, *Alexandria*
Hanback, Lawrence D Jr, *Winchester*
Hanscom, Jane L, *McLean*
Harmon, Don Laurance, *Yorktown*
Harper, Charles Edward, *Charlottesville*
Harper, Eugene Jutson, *Harrisonburg*
Harris, James Mansel, *Charlottesville*
Harris, Stuart Horsley, *Lynchburg*
Harrison, Jacquelin M, *Richmond*
Harry, Robert Roger, *Fredericksburg*
Hart, Robert Russell, *McLean*
Haymes, David William, *Richmond*
Haynes, Boyd W Jr, *Richmond*
Haynes, Jeffrey Harrison, *Richmond*
Haynsworth, Josiah E Jr, *Lynchburg*
Hazel, John Tilghman, *Warrenton*
Hebron, Desiderio Landas Jr, *Fredericksburg*
Hemric, Ned Dixon, *Norfolk*
Henderson, Raymond, *Virginia Beach*
Henretta, Thomas Ross, *Roanoke*
Henriques, Horace Fuller III, *Richmond*
Henry, C Alan, *Roanoke*
Henson, Grahame F T W, *Culpeper*
Heron, Alicia G, *Alexandria*
Hill, David Bennett, *Lynchburg*
Hill, Robert William, *Arlington*
Hill, Ronald Gene, *Lynchburg*
Hill, Stephen L, *Roanoke*
Hill, William R, *Richmond*
Hirschhorn, Jessica Betsy, *Alexandria*
Hobson, Charles Edwin, *Charlottesville*
Hoerr, George Richard, *Norfolk*
Hoffler, Oswald W, *Norfolk*
Hoffman, George Charol, *Norfolk*
Holland, John Ramey, *Norfolk*
Hollister, William Jr, *Fredericksburg*
Homa, Michael, *Annandale*
Hood, Bold Robin, *Norfolk*
Hooper, William Edward, *Covesville*
Hoover, William Benjamin, *Norfolk*
Horng, Fang, *Luray*
Horsch, Robert F, *Lebanon*
Horsley, John S, *Richmond*
Hosny, Salah, *Arlington*
Howard, Hall R, *Williamsburg*
Howell, Halstead D, *Richmond*
Howze, Herbert H, *Norton*
Hoyle, John D, *Alexandria*
Hubbard, G Wilkins II, *Norfolk*
Hubbard, Margaret Marion, *Norfolk*
Humphries, William C, *Harrisonburg*
Hutcher, Neil Edward, *Richmond*
Hutchinson, Lewis Ray, *Richmond*
Hyde, Anson R, *Virginia Beach*
Hyslop, John W, *Richmond*
Ibarra, Jorge, *Norfolk*
Irons, Robert P, *Lexington*
Irons, Robert Price Jr, *Lexington*
Irving, Declan P, *Chesapeake*
Ishitani, Michael B, *Charlottesville*
Ishizawar, Yorckay C, *Colonial Heights*
Isidro, Hermenegildo Nicolas, *Manassas*
Ives, Charles Everett, *Norfolk*
Jackson, Neville J, *Gloucester*
Jaffe, Alan Harvey, *Norfolk*
Jarrett, John Tallman, *Richmond*
Jean-Gilles, Brunet, *Norfolk*

General Surgery *(cont'd)*

Jenet, Richard Neil, *Fairfax*
Johns, William A, *Richmond*
Johnson, Brian Logan, *Virginia Beach*
Johnson, Edgar Bruce, *Glen Allen*
Johnson, Walter Smith, *Roanoke*
Jones, Mark McClellan, *Richmond*
Jones, Rayford Scott, *Charlottesville*
Jones, Robert Evans, *Charlottesville*
Joob, Axel William, *Charlottesville*
Jordan, John Sheffield, *Chesapeake*
Kamel, Medhat M, *Alexandria*
Kanithanon, Pongpijit, *Hot Springs*
Kanter, Hulbert J, *Norfolk*
Kapil, Balvir L, *State Farm*
Kastretsios, John A, *Stuart*
Kauffman, Herbert M Jr, *Richmond*
Kaufmann, Richard J, *Danville*
Keating, James Louis, *Manassas*
Kellam, E Milton, *Nassawadox*
Kelleher, Kenneth S Jr, *Woodstock*
Kelley, William Jr, *Richmond*
Kellum, John Morgan Jr, *Richmond*
Kelly, Richard John, *Alexandria*
Kennel, Elmer Elwood, *Harrisonburg*
Kessler, A Reif II, *Salem*
Khuri, Emile I, *Richlands*
Kim, Chul Wha, *Fairfax*
Kim, Young U, *Roanoke*
King, John Norman, *Norfolk*
King, John Winston, *Norfolk*
Kingsman, Kilton Deroy, *Portsmouth*
Kitterman, James S, *Norfolk*
Klepser, Roy G, *Arlington*
Kliner, Dale Joseph, *Fort Lee*
Knapp, Robert Woodruff, *Chesapeake*
Knaysi, George A, *Richmond*
Kolbeck, Scott Charles, *Charlottesville*
Kona, John Andrew, *Virginia Beach*
Koth, Douglas R, *Arlington*
Kotselas, E Nick, *Woodbridge*
Krummel, Thomas M, *Richmond*
Krusch, David A, *Charlottesville*
Kuemmerle, John Francis, *Mechanicsville*
Kulczycky, Ihor G, *Virginia Beach*
Kuperschmit, Marcelo, *Arlington*
Kurtzman, Lawrence Craig, *Portsmouth*
Kurup, Manikoth G, *Richmond*
Lacy, Matthew L II, *South Hill*
Laird, Thomas Kerr, *Danville*
Lambert, Matthew Joseph III, *Charlottesville*
Landis, John Dennis, *Front Royal*
Langer, Kenneth Frederick, *Burke*
Langley, Michael John, *Charlottesville*
Laning, Robert C, *McLean*
Lapadula, Michael F, *Arlington*
Lareau, Eugene Raymond, *Harrisonburg*
Larsen, Geoffrey Arthur, *Abingdon*
Larzelere, Henry Byron, *Lynchburg*
Law, Maynard H, *Roanoke*
Lawson, Jack A, *Newport News*
Lawson, Richard B, *Newport News*
Lee, Byung-Boong, *Oakton*
Lee, Hyung Mo, *Richmond*
Lee, Ralph N, *Newport News*
Lee, Robert Y S, *Falls Church*
Lee, Roberto Juan, *Wytheville*
Le Fon, James C, *Richmond*
Lenard, Peter Dennis, *McLean*
Lengua, Jose A, *Saluda*
Lentz, Gary Dean, *Farmville*
Leschlolarn, Likit, *Norton*
Levine, Seymour, *Fort Belvoir*
Levy, Jan Alfred, *Radford*
Lewis, David Howe, *Martinsville*
Lind, James F, *Norfolk*
Lindquist, Leo Anselm, *Danville*
Liston, William Alan, *Farmville*
Liszka, Thomas George, *Richmond*
Liszka, Victor Lorant, *Alexandria*
Lockhart, Charles Gregory, *Richmond*
Lofranco, Eduardo K, *Roanoke*
Logue, Brian John, *Alexandria*
Londrey, Gregg L, *Richmond*
Long, Ronald Arthur, *Clifton Forge*
Long, Stephen Paul, *Richmond*
Longoria, Yvette Ysaura, *Bluefield*
Lopez, Rodolfo Lagmay, *Alexandria*
Lord, Lillian R, *Rileyville*
Low, James R, *King George*
Lowe-Roche, Nanetta Bonita, *Pennington Gap*
Lucas, Chaikitch Vidhyaphum, *Arlington*
Luebbert, Phillip David, *Norfolk*
Luna, Ruben V, *Fredericksburg*
Lutenberg, Stephen P, *Manassas*
Lyons, William Stewart, *Alexandria*
Macik, Paul Edward, *Weems*
Magnant, Joseph G, *Richmond*
Mainwaring, Richard Douglas, *Charlottesville*
Malanoski, Michael Peter, *Virginia Beach*
Malthaner, Richard Adam, *Alexandria*
Manickavasagar, Sivaramalingam, *Chesapeake*
Manning, Preston Cocke, *Staunton*
Manning, Richard Gerard, *Reston*
Mansfield, John Bristow, *Harrisonburg*
Marfing, Thomas Edward, *Winchester*
Martin, Alfred J Jr, *Suffolk*
Martin, Daniel Mccall, *Glen Allen*
Martin, David E, *Warrenton*
Mason, Kenneth G, *Arlington*
Mason, Teresa Joy, *Springfield*
Massad, Louis Benedict, *Fredericksburg*
Mast, Bruce Allen, *Richmond*
Masterson, Thomas M, *Alexandria*
Matthew, Thomas Lewis, *Charlottesville*
Mayer, Thom A, *Falls Church*
Mayo, Lemuel E, *Portsmouth*
Mazzeo, John T, *McLean*
Mc Alpine, Robert E, *Suffolk*
Mc Carty, Dennis P, *Delaplane*
Mc Dannald, Eugene R Jr, *Roanoke*
Mc Dow, Russell Edward Jr, *Leesburg*
Mc Gahren, Eugene Dewey III, *Charlottesville*
Mc Gee, John Patrick, *Ridgeway*
Mc Ginn, James Sylvester, *Martinsville*
Mc Guire, Hunter H Jr, *Richmond*
Mc Hugh, Nancy Elizabeth, *Charlottesville*
Mc Keown, Joseph Edward, *Richmond*
Mc Kibbin, Douglas William, *Waynesboro*
Mc Lain, George H, *Hamilton*
Mc Lean, Robert Brennan, *Alexandria*
Mc Tamaney, James P, *Richmond*
Mellis, Michael George, *Glenn Allen*
Mendez, Manuel Diaz, *Richmond*
Mendez-Picon, Gerardo, *Richmond*
Menendez, Reinaldo III, *Emporia*
Meyer, Frederick Willer Jr, *Virginia Beach*
Meyerhoefer, Todd Alexander, *Roanoke*
Michna, Barbara Ann, *Richmond*
Midis, Milton Panos, *Richmond*
Miller, Harold W Jr, *Woodstock*
Miller, Ira David, *Virginia Beach*
Miller, Irvin S, *Alexandria*
Miller, Maurice M, *Norfolk*
Mineiro, Luiz E G, *Clifton Forge*
Minichan, David Parrish, *Roanoke*
Miranda, Josue Daniel Apilan, *Virginia Beach*
Miranda, Prospero M, *Norton*
Mitchell, Donald W, *Arlington*
Montero, Juan M II, *Chesapeake*
Montgomery, Gregory, *Harrisonburg*
Moore, James Merton III, *Alexandria*
Morales, Edmundo G, *Manassas*
Morgan, Jean Elizabeth, *McLean*
Moront, Michael George, *Arlington*
Morris, John Richard III, *Charlottesville*
Morris, John Robert, *Virginia Beach*
Morris, Willie Herman, *Lynchburg*
Moter, Lawrence Russell, *Fredericksburg*
Mourot, Arthur J, *Alexandria*
Moynihan, John Joseph, *Annandale*
Mullen, Jos Terrance, *Norfolk*
Munoz, Anthony Joseph, *Farmville*
Musapatike, Josphat Shingirai, *Chesapeake*
Nabih, Ramzy N, *Hampton*
Nabors, Lawrence Howard, *Roanoke*
Nachbar, James Milton, *Charlottesville*
Najib, Akram, *McLean*
Nase, Harold Wallace, *Farmville*
Natvig, Ralph Andreas, *Richmond*
Neal, Danny Alan, *Charlottesville*
Neifeld, James P, *Richmond*
Neville, Richard Francis, *Arlington*
Nevin, James E III, *Danville*
Newsome, Heber Hampton Jr, *Richmond*
Nguyen, Luyen Quang, *Warrenton*
Nicholson, Bradley W, *Pearisburg*
Nigro, Michael F Jr, *Alexandria*
Nirmul, Ganesh, *Suffolk*
Nutter, Paul James, *Fredericksburg*
Oates, James Franklin III, *Richmond*
O'Brien, Jeremiah Francis, *Chester*
Ocean, Ronald Hugh, *Alexandria*
Oden, Philip Wood, *Powhatan*
O'Hanlan, J Treacy, *White Stone*
Old, Levi W Jr, *Norfolk*
Old, William Whitehurst III, *Lexington*
Oliver, George J Jr, *Williamsburg*
Oltermann, Steven J, *Kilmarnock*
Oster, Niels Henrik, *Tappahannock*
Oswaks, Roy Michael, *Virginia Beach*
Owen, Earl Tracy, *Lynchburg*
Ozim, Francis Taiwo, *Norfolk*
Panbehchi, Mahmood, *Williamsburg*
Papilion, John Daniel, *Norfolk*
Parker, George A, *Richmond*

General Surgery *(cont'd)*

Parthasarathy, Thonankulam, *Big Stone Gap*
Pascual, Reymond G, *Portsmouth*
Patrick, John Ted, *Richmond*
Patterson, Henry David, *Chesapeake*
Patterson, Robert Bruce, *Portsmouth*
Payne, Robert L Jr, *Norfolk*
Payne, Solomon Celester, *Suffolk*
Payne, William Duncan, *Norfolk*
Peele, Kimberly A Piontkowski, *Williamsburg*
Peereboom, Gerrit, *Annandale*
Peery, James M, *Cedar Bluff*
Peery, W Wade, *Galax*
Pellegrini, John Louis, *Norton*
Penn, Samuel Randolph, *Waynesboro*
Penn, Thomas Jefferson, *Grundy*
Peple, William Lowndes Jr, *Richmond*
Peter, Hooshang H, *Alexandria*
Peters, Johna Harriette, *Lebanon*
Peters, Warren Richard, *Rapidan*
Petersen, Joseph M, *Waynesboro*
Peterson, John Emerick, *Annandale*
Pham, Hoang Nguyen, *Annandale*
Philippakis, Spyros, *Norfolk*
Phillips, Joseph T Jr, *Norton*
Phillips, William McLeskey, *Virginia Beach*
Piland, John Henry, *Norfolk*
Pillai, Variathu Biswanath, *Suffolk*
Pinnar, Robert Lloyd, *Annandale*
Pitman, John Mathews, *Williamsburg*
Plagata, Eduardo D, *Tazewell*
Pope, James Norford, *Bedford*
Potter, Michael Charles, *Fairfax*
Poulos, Nicholas G, *Richmond*
Powell, Robert Owen, *Norton*
Prahlad, Ashok, *Fairfax*
Prieto, Daniel C Jr, *McLean*
Pritchett, Drake, *Danville*
Pryor, Jon Lee, *Charlottesville*
Purchas, Ivor Norman, *Chesapeake*
Purkert, William J, *Annandale*
Queen, Thomas Allen, *Chesapeake*
Quioco, Heathcliff M, *Rocky Mount*
Quitiquit, Elfren Aninag, *Emporia*
Radich, Ned, *Norfolk*
Ragsdale, Thomas Hall, *Virginia Beach*
Rahman, Ahmed Abdul, *Virginia Beach*
Rahnema, Mansur, *Virginia Beach*
Rana, Riaz A, *Bluefield*
Rao, Sudhakar Jaikar, *Richmond*
Ravenel, Joseph A, *Martinsville*
Rawls, Japheth E Jr, *Suffolk*
Rawls, John Ashburn, *Richmond*
Reichman, Wayne, *Richmond*
Reid, David Settle, *Norfolk*
Reid, William Mitchell, *Alexandria*
Repass, Robert A, *Bristol*
Rhodes, Glen Robert, *Fairfax*
Ricciarelli, Giacomo A, *Hampton*
Rice, Benjamin Holt, *Petersburg*
Rice, Robert Scott, *Blacksburg*
Richards, Lewis G Jr, *Hardy*
Richardson, Constance C, *Alexandria*
Richardson, John Burnie Jr, *Richmond*
Rickerich, Charles L, *Arlington*
Riley, Charles R, *Richmond*
Rios, Juan F, *Galax*
Ritchie, William W, *Hampton*
Roberts, Ernest S, *Hampton*
Robinett, Paul Ward, *Portsmouth*
Robinson, Ralph M, *Remington*
Roda, Prospero De La Cruz, *Tappahannock*
Rogers, William B III, *Arlington*
Roll, William E Jr, *Fairfax*
Romero, Gonzalo, *Fairfax*
Rose, Joan Helena, *Annandale*
Rosenbaum, Charles Ivan, *Dillwyn*
Rosenberg, Lawrence Ira, *North Garden*
Ross, Raymond T, *Petersburg*
Rosseau, Richard Lukens, *Arlington*
Royster, Henry Page, *Richmond*
Rudolf, Leslie Eugene, *Charlottesville*
Rue, Loring Washington III, *Hampton*
Ruiz, Abelardo Antonio, *Portsmouth*
Russo, Eugene P, *Great Falls*
Ryder, Harvey B, *Virginia Beach*
Saenz, Enrique Antonio, *Norfolk*
Sale, Thomas W, *Hampton*
Sambat, Paulino D Jr, *Fredericksburg*
Samson, Justino P, *Hampton*
Sandiford, John A, *Oakton*
Sandusky, William Roberts, *Charlottesville*
Santos, Dominador S, *Harrisonburg*
Sarayba, Alberto A, *Hopewell*
Sarkar, Dilip Kumar, *Portsmouth*
Sasser, William D, *Fredericksburg*
Saunders, Maurice Edward, *Alexandria*
Sawchuk, Theodore John, *Charlottesville*
Schatken, Robert V, *Fairfax*
Schechner, Stephen A, *Virginia Beach*
Schenk, Worthington G III, *Charlottesville*
Schirmer, Bruce D, *Charlottesville*
Schlabach, Walter E, *Harrisonburg*
Schrader, Guillermo, *Tazewell*
Schroder, Gregory Louis, *Richmond*
Schwartzberg, Stuart Gerald, *Fairfax*
Scott, C Waldo, *Newport News*
Sease, James Richard, *Harrisonburg*
Sebold, Edwin James, *Virginia Beach*
Secrist, Wilbur Lowell, *Woodbridge*
Seif, Rahmat III, *Roanoke*
Seneca, Russell P, *Annandale*
Seufert, Kevin Timothy, *Virginia Beach*
Shaffrey, Mark Edwin, *Charlottesville*
Shah, Darshan N, *Norton*
Shaver, William A, *Roanoke*
Shayne, John Patrick, *Staunton*
Sheehy, James Michael, *Hampton*
Shelley, Ronald N, *Norton*
Shelton, Bonnie Lee Slayton, *Midlothian*
Shibaro, Uthman Abd-Salam, *Fairfax*
Shields, Randolph T Jr, *Staunton*
Shrum, Richard Coffman, *Charlottesville*
Shumate, George R, *Salem*
Sibley, William L III, *Salem*
Sibley, William Langley, *Roanoke*
Sidawy, Anton N, *McLean*
Silverman, Herbert R, *Danville*
Simmons, Donald Richard, *Charlottesville*
Sinclair, Terry L, *Winchester*
Slemp, Andrew Alfred Jr, *Roanoke*
Smith, David H, *Abingdon*
Smith, James Arthur III, *Lynchburg*
Smith, Mark O, *Roanoke*
Smith, Michael L, *Warrenton*
Smith, Nelson Montgomery, *Petersburg*
Smith-Harrison, Leon Ismael, *Richmond*
Smoot, John Lewis, *Fredericksburg*
Snider, John Schurr, *Irvington*
Snoddy, John William, *Richmond*
Sobel, Michael, *Richmond*
Sobhan, Ajmal, *Hampton*
Soni, Gurbax Singh, *McLean*
Soriano, Franklin M Jr, *Hampton*
Souryal, T Henry, *Alexandria*
Speilman, Daniel E, *Annandale*
Spencer, Timothy Decoudres, *Marion*
Spinosa, David Joseph, *Springfield*
Spinuzza, Elizabeth Jean, *Charlottesville*
Sprinkle, James Dean, *Danville*
Stafford, Scott Latham, *Alexandria*
Staley, J Stuart, *Marion*
Stephan, Donn Paul, *Manassas*
Stetler, Robert, *Galax*
Stevens, William Smith III, *Charlottesville*
Stevenson, Eugene O S, *Springfield*
Stokes, Thomas Ln, *Norfolk*
Stone, James Walter Jr, *Midlothian*
Stoneburner, Frank Dew Jr, *Richmond*
Stoneburner, John M, *Danville*
Sturmer, Frederick Charles, *South Hill*
Sugerman, Harvey J, *Richmond*
Sultan, Shafi Ahmed, *Pennington Gap*
Sutton, Curtis Lee, *Charlottesville*
Swensson, Erik E, *Richmond*
Talibi, Mazhar Ali, *Hampton*
Talman, Edward Armistead, *Richmond*
Tan, Alex A, *Blacksburg*
Tarasidis, George C, *Radford*
Tayko, Manuel Enfestan, *Stuart*
Taylor, Gary Lynn, *Midlothian*
Taylor, Leah Teekell, *Earlysville*
Teague, Francis B Jr, *Lynchburg*
Temeck, Barbara Kathleen, *Arlington*
Tette, Amadea, *Annandale*
Thiel, Martin A, *Williamsburg*
Thomas, Brian Lacy, *Glen Allen*
Thompson, Frederick N, *Newport News*
Thompson, Richard N, *Fredericksburg*
Todd, John W III, *Mt Solon*
Tolosa, Eduardo T, *Tazewell*
Toms, Bate C Jr, *Martinsville*
Torres, William Dennis, *Richmond*
Tran, Doan, *Fairfax*
Tran, Tu Anh, *Roanoke*
Trinidad, Juan A, *Vienna*
Tuazon, Oscar C, *Alexandria*
Tucker, Henry Joseph, *South Boston*
Turgeon, Daniel G, *Annandale*
Ukoh, Alexander E, *Fairfax*
Ulich, Paul John, *Virginia Beach*
Umstott, Charles Edward, *Newport News*
Vafier, James Alexander, *Springfield*
Van Geertruyden, H H, *Norfolk*
Van Horn, C Newton, *Norfolk*
Van Slyke, Karl K, *Charlottesville*
Vander Vennet, Kenneth R, *Newport News*
Vansant, John H, *Norfolk*
Vasquez, Javier A, *Arlington*
Vaughan, Leah Mary, *Chesapeake*
Veltri, Benjamin J, *Manassas*

General Surgery *(cont'd)*

Vick, Clyde Whitley Jr, *Petersburg*
Vinh, Dai, *Fairfax*
Vinh, Lam Vien, *Fairfax*
Von Oettingen, Dieter R, *Manassas*
Wagner, Robert C, *Arlington*
Waldhausen, John Henry Trescher, *Charlottesville*
Walker, Rome Haward, *Roanoke*
Walls, Walter S, *Charlottesville*
Walsh, Robert Stewart, *Charlottesville*
Walton, William Watkins, *Pulaski*
Wampler, J Paul, *Manassas*
Watkins, William Randolph, *South Boston*
Webb, Michael Andre, *Virginia Beach*
Webster, Wade West, *Norfolk*
Wechsler, Andrew Stephen, *Richmond*
Weems, Bliss King, *Waynesboro*
Weinberg, Samuel E, *Hampton*
Weireter, Leonard J Jr, *Norfolk*
Weitzman, Douglas Keith, *Norfolk*
Wente, John Anthony Jr, *Bedford*
West, Richard Duane, *Virginia Beach*
Whalen, Thomas Vincent, *Chesapeake*
Wheeler, Jock Rodgers, *Norfolk*
Whisnant, Robert Andrew, *Virginia Beach*
White, George Erhardt, *Vienna*
White, James Latham, *Manassas*
Whitesell, Frank B, *Arlington*
Whitesell, Frank B Jr, *Arlington*
Whitley, Ronald E, *Richmond*
Whitlock, Lee E Jr, *Norfolk*
Whitman, William Rush Jr, *Goodview*
Wiedower, James S, *Winchester*
Wienke, James W, *Pulaski*
Wilhelm, Morton C, *Charlottesville*
Williams, Armistead M, *Richmond*
Williams, Carrington Jr, *Irvington*
Williams, Edwin Leon II, *Roanoke*
Williams, Harold L, *Newport News*
Williams, Richard Stuart, *Hampton*
Williams, Samuel II, *Roanoke*
Wilson, Wayne Hilton, *Salem*
Winfrey, Elisha W III, *Newport News*
Winkler, Charles Pinckney Jr, *Richmond*
Wirth, John Clarence Jr, *Newport News*
Wise, Alan Jr, *Arlington*
Wohlgemuth, Stephen D, *Norfolk*
Wolf, Jeffrey Stephen, *Portsmouth*
Woodard, Dean Harris, *Staunton*
Wright, Thomas M, *Annandale*
Yee, Kim Brian, *Danville*
Yon, Joseph Langham, *Portsmouth*
Youel, John Kenneth Jr, *Charlottesville*
Yutzy, Carl Vernon, *Gloucester*
Zamzam, Salih M, *Grundy*
Zimmerman, Barklie W, *Richmond*

Geriatrics

Bourhill, Graham H, *Marion*
Fineman, Bill L, *Woodbridge*
Hamrick, Robert Arnold, *Williamsburg*
Helfer, Lawrence S, *Salem*
Lynch, John P, *Richmond*
Mac Donald, Robert Gene, *Midlothian*
Poe, William D, *Roanoke*
Sims, John Adrian, *Alexandria*

Gynecology

Acosta, Anibal, *Norfolk*
Andrews, William Cooke, *Norfolk*
Armentrout, Clement S, *Harrisonburg*
Bickers, William M, *Richmond*
Blades, James Franklin, *Richmond*
Brandt, Volker, *McLean*
Byrd, William Edward, *Norfolk*
Cowell, Pamela D, *McLean*
Edmunds, Frederick T, *Lexington*
Fifer, Carson Lee, *Alexandria*
Foegh, Marie L, *McLean*
Hoge, Randolph H, *Richmond*
Howren, Harry H Jr, *Richmond*
Jones, Georgeanna Seegar, *Norfolk*
Jones, Howard W Jr, *Norfolk*
Kight, John Randolph, *Virginia Beach*
Knudson, Homer E, *Vienna*
Levin, Gershon J, *Norfolk*
Littlepage, Eleanor G M, *Norfolk*
Martin, Shirley S, *Locust Grove*
Michaux, Richard A, *Richmond*
Naccash, Edmund P, *Fairfax*
Nedelcovych, Sava M, *Alexandria*
Nicholls, Richard B, *Norfolk*
Parker, Joseph C, *Richmond*
Parrish, Bernard L, *Deltaville*
Redford, Ramon N Jr, *Virginia Beach*
Robins, Spotswood Jr, *Richmond*
Ruth, Gerald Jay, *Roanoke*
Smith, Arthur Morton Jr, *Charlottesville*
Taylor, Helen Wickham, *Norfolk*
Thomas, Pendleton Emmett, *Richmond*
True, De Witt S, *Portsmouth*
Underwood, Paul B Jr, *Charlottesville*
Warren, Joseph Edwin, *Lynchburg*
Wilks, John William, *Roanoke*

Hand Surgery

Aulicino, Pat Louis, *Chesapeake*
Bergfield, Thomas G, *Chesapeake*
Bowers, William H, *Richmond*
Gwathmey, Frank W, *Norfolk*
Mc Cue, Frank C III, *Charlottesville*
Mc Dowell, Charles L, *Richmond*
Silversmith, Peter E, *Alexandria*

Head/Neck Surgery

Ackell, Edmund F, *Richmond*
Jones, Michael C, *McLean*

Hematology

Adelman, Burt Alan, *Richmond*
Binder, Richard Allen, *Annandale*
Caldwell, David Clark, *Danville*
Crockett, Charles L Jr, *Roanoke*
Desch, Christopher E, *Richmond*
Dobrzynski, Robert F, *Alexandria*
George, Edward Richard, *Virginia Beach*
Halpin, John J, *Lynchburg*
Heaton, William A, *Norfolk*
Hess, Charles Edwin, *Charlottesville*
Joshi, Harshvadan Pradyumn, *Springfield*
Kandahari, Masoom M, *Arlington*
Katcher, Daniel, *Woodbridge*
Kennedy, Stephen S, *Roanoke*
Kostinas, John E, *Chesapeake*
Major, William B, *Winchester*
Mc Carthy, Patrick John, *Roanoke*
Meister, Robert Jay, *Arlington*
Miles-Richardson, Gurnel E, *Newport News*
Miller, Charles Valentine, *Fredericksburg*
Miller, John Alfred, *Annandale*
Mintz, Paul D, *Charlottesville*
Mohler, Daniel N Jr, *Charlottesville*
Nayfield, Susan G, *Richmond*
Parker, Gregory Alan, *Richmond*
Schwarz, Maurice Chaskiel, *Richmond*
Shen, Vincent S, *Virginia Beach*
Sibley, Denise Swink, *Charlottesville*
Smith, Leroy Fleming Jr, *Alexandria*
Smith, Wade K, *Richmond*
Spyker, Daniel A, *Charlottesville*
Sternlicht, Ludwig, *Virginia Beach*
Thornsvard, Charles T, *Harrisonburg*
Tucker, Henry St George III, *Richmond*
Vance, Samuel Franklin, *Roanoke*
Warfield, Melissa A, *Norfolk*

Hypnosis

Ward, Winfred O'Neil, *Richmond*

Infectious Diseases

Bernstein, Norman D, *Fredericksburg*
Blevins, Douglas Dane, *Salem*
Christopher, George W, *Alexandria*
Francis, James B, *Roanoke*
Galbraith, Mark, *Winchester*
Green, Stephen Lloyd, *Hampton*
Groschel, Dieter H, *Charlottesville*
Haggerty, Patrick G, *Hampton*
Hewlett, Erik L, *Charlottesville*
Kancir-Azer, Ljubica M, *Alexandria*
Kannan, Mickael M, *Richmond*
Morrison, Allan J Jr, *Annandale*
Poretz, Donald Martin, *Annandale*
Reines, Eric D, *Alexandria*
Stine, Terry Mcroe, *Arlington*
Yoshikawa, Thomas Toyokazu, *Arlington*

Internal Medicine

Abernathy, Robert A Jr, *Richlands*
Abramson, Stephen Nathaniel, *Richmond*
Accettola, Robert James, *Chesapeake*
Adams, Walter Paul, *Norfolk*
Adler, Robert Alan, *Richmond*
Agarwal, Madhulika Jain, *Alexandria*
Agustin, Lourdes Alquiros, *Virginia Beach*
Ahlgren, James D, *McLean*
Ahmad, Syed Mahmood, *Bluefield*
Akins, David Lee, *Portsmouth*
Al-Abdulla, Hamid M, *Richmond*
Alarif, Adhid Ismail, *Great Falls*
Albers, William Richard, *Fairfax*
Alden, Susan Leslie, *Norfolk*
Alexander, Edward L Jr, *Newport News*
Alexander, H C III, *Roanoke*
Alexander, Michael B, *Arlington*

Internal Medicine *(cont'd)*

Alfriend, Robert Whitehead, *Norfolk*
Alisuag, Andres Jr, *Manassas*
Allchin, Carol Louise, *Arlington*
Allen, Deborah Goode, *Clifton Forge*
Allen, Frederick James, *Catawba*
Allen, Yorke III, *McLean*
Allenby, Kent S, *Falls Church*
Aller, James D, *Charlottesville*
Alquiros-Agustin, Lourdes, *Virginia Beach*
Amari, Salvatore N, *Leesburg*
Ambury, James F, *Arlington*
Amedeo, Ralph M, *Arlington*
Ameen, Richard J, *Fredericksburg*
Amin, Surendra P, *Alexandria*
Amonette, Wilbur F, *Radford*
Amos, William C, *Springfield*
Andersen, Fritz H, *Arlington*
Anderson, Brian Cornell, *Virginia Beach*
Anderson, Charles C, *Chesapeake*
Anderson, Daniel Norman, *Norfolk*
Anderson, Douglas James, *Richmond*
Anderson, William Morris, *Williamsburg*
Anderson, William Robert Jr, *South Hill*
Andrew, John Alan, *Leesburg*
Andriuk, Alexander John, *Arlington*
Angello, Debra Ann, *Charlottesville*
Anglin, Victor T Jr, *Virginia Beach*
Angoso, Manuel, *Falls Church*
Ansell, Burness Ferdinand, *Richmond*
Antal, Elizabeth Franki, *Alexandria*
Antus, John Lawrence, *Manassas*
Apple, Darrell J, *Alexandria*
Apter, Ronald Alan, *Falls Church*
Arakaky-Salazar, Abel, *Arlington*
Archer, Gordon L, *Richmond*
Armstrong, John H, *Winchester*
Arrage, Antoine A, *Virginia Beach*
Arrowood, James A, *Richmond*
Arthur, Robert Miller, *Richmond*
Artz, Ronald P, *Richmond*
Ascunce, Gil, *Arlington*
Ashby, Charles C Jr, *Norfolk*
Ashworth, John Sheriden, *Richmond*
Atchison, Joseph L, *Alexandria*
Atchley, William Doyle, *Norfolk*
Atuk, Nuzhet O, *Charlottesville*
Augenstein, H Nicholas, *Chesapeake*
Ault, Peter N Jr, *Charles City*
Austin, Eva M, *Great Falls*
Auzins, Dace, *Norfolk*
Avezzano, Eric Stuart, *Arlington*
Ayers, Carlos R, *Charlottesville*
Backstrom, James Wilbert, *Woodbridge*
Baganz, Herbert M Jr, *McLean*
Bagnick, Joseph Francis, *Newport News*
Bailey, Charles C, *Charlottesville*
Bailey, Dewey James, *Roanoke*
Bailey, Dewey James III, *Richmond*
Bailey, Lawrence Delmore Jr, *Charlottesville*
Bailey, Robert Liston Jr, *Weems*
Bain, Thomas Herbert, *Crozet*
Baker, James Russell Jr, *Alexandria*
Baker, Stuart B, *Norfolk*
Baker, William B, *Danville*
Bakht, Shoaib, *Portsmouth*
Balakrishnan, Sivaramalingam, *Norfolk*
Baldwin, Ernest Frank III, *Lexington*
Ball, Michael Francis Jr, *Annandale*
Ball, Michael J, *Richmond*
Ballenger, Fred Jackson, *Roanoke*
Ballou, Charles F, *Clifton Forge*
Ballou, James Elon, *Clifton Forge*
Ballou, Michele Krick, *Norfolk*
Bandy, Maurice E, *South Boston*
Banks, Alan Kirk, *Alexandria*
Baradhi, Nabil Shakeib, *Richmond*
Barbour, Galen Lane, *Newport News*
Barney, William H, *Lynchburg*
Barongan, Amor A, *Norton*
Barongan, Pablo P, *Norton*
Barrera, Francisco R, *Woodbridge*
Barrett, Michael Arthur, *Arlington*
Barritt, A Sidney III, *Salem*
Barrow, Guy J, *Abingdon*
Barry, Fredrick, *Radford*
Bartis, Lois Cohen, *McLean*
Bartman, Barbara Ann, *Arlington*
Basham, Mark Cash, *Virginia Beach*
Bashore, Randall Thomas, *New Canton*
Basile, Michael Joseph, *Roanoke*
Bastani, Ali, *Woodbridge*
Bauernfeind, Robert Allen, *Richmond*
Bauknight, Gerald Conrad Jr, *Richmond*
Baylor, Richard Norton, *Kilmarnock*
Beavers, William Jefferson, *Virginia Beach*
Bechard, Daniel E, *Richmond*
Beck, Lucille Singer, *Arlington*
Becker, Daniel Martin, *Charlottesville*
Becker, Elmore James, *Richmond*
Becker, Francis Evans, *Falls Church*
Bedichek, Ellen Gracy, *Richmond*
Bedinger, Robert W Jr, *Richmond*
Bedinger, Robert W Sr, *Richmond*
Behnke, Lisa Marie, *Marion*
Belcher, Birgit E, *Virginia Beach*
Bell, George Milton, *Salem*
Bell, Gerald I, *Alexandria*
Bell, Patricia Evelyn, *Richmond*
Beller, George Allan, *Charlottesville*
Belz, Michael Kenneth, *Richmond*
Bender, Arthur Stillman, *Charlottesville*
Bengtson, Carolyn Rae, *Nassawadox*
Benish, Robert Vincent, *Galax*
Bennett, James Pepper Jr, *Charlottesville*
Benton, James Bernard, *Richmond*
Beorn, Charles F, *Powhatan*
Bera, Dilipkumar Mohan, *Sterling*
Berberich, Joel John, *Richmond*
Berenfeld, Sharon Ann, *Chesterfield*
Berger, Keith Edward, *Virginia Beach*
Berger, Kenneth W, *Falls Church*
Bergman, Kenneth Robert, *Annandale*
Berk, Barbara Z, *Charlottesville*
Berlin, Irving, *Hampton*
Berling, Donald Paul, *Virginia Beach*
Bern, Merritt Jonathan, *Salem*
Bernanke, A David, *Alexandria*
Bernart, William Francis, *Nassawadox*
Berns, Jeffrey Scott, *Fairfax*
Bernstein, Jonna L, *Danville*
Berry, Alison Joan, *Richmond*
Berry, Jacqueline Rosanna, *Springfield*
Berry-Riley, Faye Moye, *Virginia Beach*
Bertram, Edward Hiltner III, *Charlottesville*
Bertran, Jorge L, *Falls Church*
Besch, George Andrew, *Alexandria*
Best, David Walker, *Virginia Beach*
Betcher, Sylvia Louise, *Richmond*
Bethea, William M Jr, *Norfolk*
Beuttel, Stephen C, *Chesapeake*
Bharani, Paluvai Ramakrishna, *Sterling*
Bhat, Shridhar V, *Richmond*
Bhushan, Neeraj, *Burke*
Bickelmann, Albert George, *Vienna*
Bienia, Richard A, *Norfolk*
Bigoney, Rebecca M, *Fredericksburg*
Bilisoly, Frank N III, *Norfolk*
Birch, Bruce M, *Blacksburg*
Birk, Peter, *Virginia Beach*
Bishai, Adel Gendy, *Emporia*
Bithell, Thomas Carter, *Charlottesville*
Black, James B Jr, *Richmond*
Blackard, William G, *Richmond*
Blackman, William Allison, *Lynchburg*
Blair, Lacy G, *Lynchburg*
Blair, Timothy Pierce, *Vienna*
Blais, David P, *Norfolk*
Blank, Melanie Jaye, *Falls Church*
Blanton, Frank M, *Richmond*
Blanton, Wyndham B Jr, *Farmville*
Blattner, Carlos Luis, *Marion*
Bloom, Marvin Eugene, *Falls Church*
Bloom, Robert L, *Falls Church*
Blow, Alton Joseph Jr, *Norfolk*
Blum, Ronald M, *Martinsville*
Blunk, Karen L, *Suffolk*
Bobrik, Linda Zimmerman, *Dale City*
Boggs, Jane Gilbert, *Richmond*
Bohan, Michael E, *Portsmouth*
Boice, Douglas B, *Chesapeake*
Boland, Brian J, *Arlington*
Boling, Peter Avery, *Richmond*
Bolton, Warren Kline, *Charlottesville*
Bond, Oliver B, *McLean*
Bondurant, Robert F, *Salem*
Boniface, John Jr, *Fredericksburg*
Bonner, Lloyd Arden, *Richmond*
Booker, George E Jr, *Portsmouth*
Boone, Luther Roy, *Virginia Beach*
Booth, Bruce W, *Newport News*
Borden, Denise Louise, *Richmond*
Borsody, Frank J, *Gainsville*
Bosworth, David C, *Newport News*
Bourne, Henry Reid, *Danville*
Bowden, James Harris, *Abingdon*
Bowen, Patrick James, *Annandale*
Bowers, John Thomas, *Norfolk*
Bowser, Barrington H Jr, *Richmond*
Boyd, John William, *Norfolk*
Boyd, Milton Alexander, *Richmond*
Bradenham, Ben Persons, *Richmond*
Bragg, Leroy P, *Hampton*
Brannen, Judy Lynn, *Richmond*
Branscome, William Carl, *Staunton*
Brantley, Kenneth Michael, *Crozet*
Bray, Maurice Miller, *Suffolk*
Brayshaw, James Rodney, *Alexandria*
Brayton, Carol, *Alexandria*
Breene, Dennis Patrick, *Portsmouth*
Breit, Harvey Jerome, *Portsmouth*
Brennan, Robert O, *Lynchburg*
Brickhouse, Robert L, *Charlottesville*

Internal Medicine *(cont'd)*

Brodeur, James Philip, *Mechanicsville*
Brooks, Charles Harris, *Harrisonburg*
Brooks, John Jr, *Norfolk*
Brooks, Kenneth Mark, *Falls Church*
Broome, Jesse Michael, *Virginia Beach*
Brothers, Pamela J, *Richmond*
Brown, Alexander G III, *Richmond*
Brown, Curtis W, *Virginia Beach*
Brown, Gary Eugene, *Alexandria*
Brown, Loretta Port, *Hampton*
Brown, Thomas McPherson, *Arlington*
Brown, William Martin, *Lynchburg*
Browne, Roger Wayne, *South Boston*
Brownley, Edwin Treakle, *Norfolk*
Bruce, Thomas Alfred, *Falls Church*
Bruder, Jan M, *Richmond*
Brummer, Donald L, *Richmond*
Brunner, Carolyn Marie, *Charlottesville*
Bryan, Joe Paul, *McLean*
Bryant, James Edwin, *Kilmarnock*
Bryant, Robert Singleton, *Harrisonburg*
Buchanan, Brian D, *Bedford*
Buchanan, John C, *Wise*
Buchanan, William Edward, *Hampton*
Bucher, Bruce M, *Tappahannock*
Buchsbaum, David G, *Richmond*
Budd, Samuel Walthall Jr, *Richmond*
Bulger, Elizabeth Ann, *Fairfax*
Bullock, John Boyd, *Richmond*
Bullock, Robert Graham, *Arlington*
Burch, Christina Marshall, *Richmond*
Burge, Joseph John, *Charlottesville*
Burger, Robert Lindsay, *Norfolk*
Burgess, John Thompson, *Falls Church*
Burka, Steven Arthur, *Great Falls*
Burke, Gene H, *Norfolk*
Burke, James O, *Richmond*
Burris, Allen Stuart, *Richmond*
Burslem, William Ashworth Jr, *Winchester*
Burton, William Stewart, *Nassawadox*
Burwell, Lawrence R, *Charlottesville*
Butch, Rodney James, *Fairfax*
Butler, Thomas Parke, *Arlington*
Byrd, Allison Dickson, *Virginia Beach*
Byrd, John Abbott, *Norfolk*
Byrne, Patrick John, *Alexandria*
Byrne, William Russell, *Richmond*
Caday, Antonio T, *Richlands*
Cadsawan-Deluciano, M T M, *Arlington*
Cain, Anne, *Roanoke*
Caldwell, David Stewart, *Danville*
Cale, William F, *Harrisonburg*
Call, John Daniel, *Richmond*
Callahan, Daniel Francis, *Richmond*
Callahan-Lyon, Priscilla, *Staunton*
Calope, Petrus T, *Tazewell*
Calvert, Richard John, *Arlington*
Camden, Daniel McClung, *Salem*
Camden, Sharon Sullivan, *Richmond*
Camp, James L III, *Charlottesville*
Camp, Robert Michael, *Norfolk*
Campbell, David Allen, *Midlothian*
Campbell, George Wesley, *Chesterfield*
Cannon, David Robert, *Lynchburg*
Cannon, M Marci, *Roanoke*
Cantrell, Eleanor Sue, *Wise*
Caplan, Martin D, *Richmond*
Caplan, Michael A, *Danville*
Cappello, Roger W, *Mechanicsville*
Capps, John Lawton, *Richmond*
Carideo, Louis N, *Chesapeake*
Carithers, Robert L, *Richmond*
Carle, Kenneth Alan, *Charlottesville*
Carleton, Robin Ann, *Roanoke*
Carpenter, J T Jr, *Charlottesville*
Carr, Marcus Eugene, *Richmond*
Carson, Barbara A, *Fairfax*
Cartmell, Jo Ellen, *Annandale*
Carty, James Walker Jr, *Norfolk*
Cary, Freeman Hamilton, *Charlottesville*
Cary, John Francis, *Manassas*
Casey, Carlton J, *Williamsburg*
Casey, William C, *Annandale*
Casolaro, M Anthony, *Arlington*
Cassidy, William John, *Falls Church*
Castle, James R, *Roanoke*
Catalan, Manolita O, *Marion*
Cates, Robert Judson, *Oakton*
Catlett, Joseph Patrick, *Richmond*
Catron, Stuart H Jr, *Abingdon*
Cay, Mehmet Nuri, *Fairfax*
Cejas-Rosas, Rodolfo, *Norfolk*
Centor, Robert M, *Richmond*
Cetron, Martin Stuart, *Charlottesville*
Chadha, Vijay Kumar, *Herndon*
Champ, Raynido Alfonso, *Portsmouth*
Chance, Joseph F, *Charlottesville*
Changizi, M H, *Annandale*
Chao, Yu-Hua, *Alexandria*
Chapman, James E, *Falls Church*
Chapman, Rees Cecil, *Norfolk*
Chapman, William Holmes Jr, *Suffolk*
Charlton, Jaehn B, *Reedville*
Chasse, Robert Thomas, *Norfolk*
Chaudhry, Yusuf Mohammed, *Grundy*
Chauhan, Ajit Singh, *Leesburg*
Chazen, Geoffrey David, *Fairfax*
Chemplavil, Joseph K, *Hampton*
Cheriyan, Ranjit Kizhaketalikal, *Annandale*
Cherwek, Michael L, *Fredericksburg*
Chesler, David L, *Charlottesville*
Chesnut, John L, *Warm Springs*
Chevalier-Seawell, Maureen, *Norfolk*
Childress, Stuart P Jr, *Winchester*
Chin, Judy Ling, *Fairfax*
Chinnery, Lind Walter, *Hampton*
Chinnis, Ann Short, *Irvington*
Chitwood, James Logan, *Pulaski*
Chiu, Ming Sung, *Petersburg*
Choi, Byung-Il, *McLean*
Choi, Hinsing Steven, *Norfolk*
Chudasama, Laxmikant Harjivan, *South Hill*
Chun, Hoo Geun, *Vienna*
Chusid, Aram, *Falls Church*
Cilecek, James W, *Fairfax*
Cirenza, Emanuel, *Arlington*
Cirillo, Nicholas B, *Springfield*
Clance, Keith Montgomery, *Glen Allen*
Clancy, Carolyn Maureen, *Richmond*
Clardy, John T, *Newport News*
Clark, Carl V, *Danville*
Clark, Kenneth Alan, *Virginia Beach*
Clark, Laurence J, *Alexandria*
Clark, Mark W, *Hampton*
Clark, Ralph Raymond, *Richmond*
Clark, Thomas Harding, *Alexandria*
Clarkson, Sarah Bull, *Norfolk*
Clauw, Daniel Joseph, *Falls Church*
Clayton, Michael Thomas, *Gordonsville*
Cleary, John Brian, *Fairfax*
Clemo, Simon Henry Francis, *Richmond*
Clifford, Gregg Richard, *Charlottesville*
Clore, John Newton, *Richmond*
Coar, Daniel Nelson, *Chesapeake*
Cobbs, Elizabeth Lipton, *Arlington*
Cochran, John Wesley, *Alexandria*
Cofer, Vernon L Jr, *Norfolk*
Cohen, Alan M, *Norfolk*
Cohen, Alvin, *Petersburg*
Cohen, Mark Dexter, *Richmond*
Cohen, Michael Robert, *Petersburg*
Cole, Carmella Ann, *Falls Church*
Cole, Donald A, *South Boston*
Cole, Marilee C S, *McLean*
Coleman-Batties, Linda Elaine, *Arlington*
Collins, Vincent Ross, *Alexandria*
Conaway, Don Lee, *Virginia Beach*
Conde, Miguel Angel, *Arlington*
Conkling, Paul Robert, *Norfolk*
Connally, Nathaniel T Jr, *Arlington*
Connelly, Julia Elizabeth, *Charlottesville*
Connito, David John, *Chesapeake*
Conwit, Robin Andrea, *Arlington*
Coo, Albert Wu, *Alexandria*
Cook, John H III, *Leesburg*
Cook, John Joseph, *Norfolk*
Cooper, Kevin Richard, *Richmond*
Copeland, David Lynn, *Lexington*
Copperman, Reuben, *Arlington*
Corbett, Eugene Charles Jr, *Fork Union*
Corcoran, David M, *Arlington*
Corinaldi, Greg Austin, *Alexandria*
Corley, Sarah T, *Charlottesville*
Corrado, Michael A, *Sterling*
Cosentino, Raymond F, *Alexandria*
Cossa, Nicholas A, *Oakton*
Costescu, Sanda, *Arlington*
Cothran, Malcolm L Jr, *Lexington*
Cottrell, John Austin Jr, *Woodstock*
Coudon, Wilson L, *Arlington*
Cowley, Michael J, *Richmond*
Cox, James M, *Lynchburg*
Craddock, George B Jr, *Charlottesville*
Craig, James William, *Charlottesville*
Crampton, Richard S, *Charlottesville*
Crane, John Kenneth, *Charlottesville*
Crane, T Jefferson, *Richmond*
Crantz, Frank R, *McLean*
Crantz, Joanne G, *Annandale*
Crews, James R, *Lexington*
Crispell, Kenneth R, *Charlottesville*
Crook, Jerry Jackson, *Lexington*
Cross, Steven W, *Richmond*
Crowder, Margaret E, *Petersburg*
Crowder, R Vincent Jr, *Lynchburg*
Crowder, Richard F, *Gloucester*
Cullen, Richard L Jr, *Norfolk*
Culpepper, Clifford P, *Radford*
Culpepper, Roy Michael, *Midlothian*
Cumbia, Jesse W, *Charlottesville*
Cummings, Charles E, *Richmond*
Cundiff, David M, *Norfolk*

Internal Medicine *(cont'd)*

Cure, James Dillon, *Lynchburg*
Currie, Randall Byron Jr, *Fredericksburg*
Dabney, William Taylor, *Richmond*
Dacher, Elliott S, *Reston*
Daffner, John E, *Roanoke*
Dajani, Zuhdi Mohamed, *Vienna*
Dandridge, William Robert, *Charlottesville*
Daniel, Donald Snead Jr, *Richmond*
Daniel, John M III, *Richmond*
Daniels, Warren C, *Hopewell*
Daquioag, Eleanor Peneyra, *McLean*
Daub, Denise Marie, *Norfolk*
David, Marigail Wynne, *Richmond*
Davidson, Dwight Douglas, *Marion*
Davidson, Eric N, *Danville*
Davis, Richard Lee, *Arlington*
Davis, Robert Stephen, *Petersburg*
Davis, Robert T, *Ware Neck*
Davis, Thomas D Jr, *Richmond*
Debell, William Keith Sr, *Charlottesville*
De Butts, Richard E, *Upperville*
Decenso, Diane Marie, *Virginia Beach*
Decker, Gary Raymond, *Alexandria*
Decker, Henry Chesley, *Richmond*
Deep, William Daniel, *Richmond*
Deeter, William Taylor III, *Charlottesville*
Degen, Douglas B, *Staunton*
Deiss, William Paul, *Richmond*
Dejo, Julio A, *Fairfax*
Dejuk, Miguel G, *Falls Church*
De La Cruz, Fausto A, *Norfolk*
Delaney, Morgan D, *Alexandria*
Delery, Alfred Albert, *Berryville*
Demicco, Deborah Diane, *Roanoke*
Dempsey, John Joseph, *Smithfield*
Denio, Alfred Elon, *Norfolk*
Dennis, Phillip M, *Hampton*
De Paola, Delia, *Arlington*
Desai, Narendra Gulabbhai, *Alexandria*
Desai, Ramesh M, *Arlington*
Desanto, John Anthony, *Richmond*
Desouza, Romaldo F X, *Alexandria*
Desper, Paul Carlton, *Manassas*
Di Giovanni, Susan Rosalie, *Richmond*
Di Pinto, Felix Roberto, *Alexandria*
Dibner-Dunlap, Mark Evans, *Richmond*
Dickerson, Shelby Clark, *Roanoke*
Dilorenzo, Anthony, *Arlington*
Dimarco, John Philip, *Charlottesville*
Dingledine, William S, *Richmond*
Di Sario, Anthony Rynham, *Arlington*
Dixon, Leon M, *Richmond*
Doan, Ba Van, *Falls Church*
Doan, Phuoc Kim, *Falls Church*
Doerman, Randall L, *Oakton*
Domm, Bill Murrie, *Williamsburg*
Dondiego, Richard Michael, *Hampton*
Donlan, Charles J Jr, *Norfolk*
Donovan, Eugene Anthony, *Burkeville*
Donowitz, Gerald R, *Charlottesville*
Dooley, Mark C, *Richmond*
Dooley, Parker Clark, *Melfa*
Dotson, Gary Wesley, *Grafton*
Douglas, Michael Forbes, *Richmond*
Downs, Robert Woodward Jr, *Richmond*
Drake, Charles Roy Jr, *Winchester*
Drake, John Edward, *Richmond*
Dreher, Norman J, *Abingdon*
Duma, Richard J, *Richmond*
Dumville, David Milton, *Richmond*
Duncan, James M, *Williamsburg*
Du Rocher, Frances A, *Fairfax*
Dvorak, Josef C, *Arlington*
Dvorak, Vera C, *McLean*
Dwyer, Thomas Edward, *Richmond*
Dye, Kevin Randell, *Roanoke*
Earle, Rona Harthill, *Springfield*
Easton, Richard E, *Virginia Beach*
Eckberg, Dwain L, *Richmond*
Edelheit, Donald C, *Virginia Beach*
Edelson, Gary W, *Arlington*
Eder, Edward Ernest, *Alexandria*
Edmonds, Robert William, *Roanoke*
Edmondson, William P Jr, *Norfolk*
Edmunds, B Prescott Jr, *Lynchburg*
Edwards, Alan W, *Franklin*
Edwards, Oscar Edmunds, *Norfolk*
Edwards, Richard Thomas III, *Roanoke*
Edwards, Robert G, *Franklin*
Edwards, Thomas S, *Barboursville*
Eggerman, Thomas L, *Arlington*
Eich, David Meeks, *Richmond*
Eisenbaum, Marc A, *Fairfax*
El-Amin, Sundiata Mustafaa, *Newport News*
Elder, Thomas David, *Norfolk*
Eldridge, Thomas Haws, *Roanoke*
Ellenberg, Russell C, *Chester*
Ellenbogen, Kenneth Alan, *Richmond*
Ellis, Frank F Jr, *Roanoke*
Ellis, Rodney L, *Falls Church*
Ellis, William Wallace, *Winchester*
Ellison, Oscar Jr, *Falls Church*
Ende, Frederick I, *Petersburg*
Ende, Mark, *Petersburg*
Ende, Milton, *Petersburg*
Endres-Bercher, Gregory John, *Richlands*
Enelow, Richard Ian, *Charlottesville*
Enelow, Robert Stewart, *Burke*
Eng, Margaret Hom, *Annandale*
Engelhardt, Elizabeth Jane, *Alexandria*
Eragan, Mehmet Arif, *Alexandria*
Ericksen, Thomas W, *Alexandria*
Erickson, Nicholette Lingon, *Richmond*
Erlandson, David Andrew, *Alexandria*
Erwin, William Swadley, *Roanoke*
Esau, Sharon Ann, *Charlottesville*
Escasinas, Edgar Rivera, *St Paul*
Eskew, James Ronald, *Alexandria*
Esposito, Aldo Richard, *Falls Church*
Essig, Le Roy John, *Fredericksburg*
Esswein, John George, *McLean*
Estep, Herschel Leonard, *Norfolk*
Eurenius, Karl, *Troutville*
Evans, Charles Garland Jr, *Glen Allen*
Evans, Eleanor Freed, *Midlothian*
Evans, Thomas George, *Charlottesville*
Evans, William S, *Charlottesville*
Everett, Lucinda Lee, *Richmond*
Evett, Russell D, *Norfolk*
Ewart, George E, *Richmond*
Facen, Harold T, *Arlington*
Fagan, Roy Otho, *Roanoke*
Fairman, R Paul, *Richmond*
Falgui, Vicente T, *Danville*
Falls, William Franklin Jr, *Richmond*
Fanucci, Karen Marie, *Arlington*
Fariss, Bruce Lindsay, *Allisonia*
Farnsworth, David I, *Richmond*
Farr, Barry Miller, *Charlottesville*
Farrar, John Thruston, *Richmond*
Fears, Jonathan Kim, *Reston*
Fecanin, Peter Jay, *Fairfax Station*
Fedson, David S, *Charlottesville*
Feinberg, Elliot Jay, *Arlington*
Fekete, Andrew Maurice, *Norfolk*
Feldman, Marc David, *Charlottesville*
Fender, Gary R, *Arlington*
Fenn, James David, *Norfolk*
Ferrar, William Lewis, *Richmond*
Ferrer, Rosario Cabrera, *Springfield*
Field, Laraine Terry, *Alexandria*
Fields, Branch Tucker Jr, *Hampton*
Filart, Roland Agcaoili, *Arlington*
Findley, Larry J, *Charlottesville*
Fine, Ronald, *Great Falls*
Fink, Sidney, *Hampton*
Finlayson, Douglas Ashley, *Norfolk*
Fintel, William A, *Roanoke*
Fischer, George L, *Clifton Forge*
Fischer, Leonard S, *Reston*
Fishburne, Cary N, *Charlottesville*
Fisher, Hugh P Jr, *Richmond*
Fisher, Michael Joseph, *Charlottesville*
Flaherty, Michael J, *Hopewell*
Fleagle, Jane Anne, *Dryden*
Fleming, Ron Delayne, *Charlottesville*
Flemming, Donald Joel, *Virginia Beach*
Flockhart, David Alastair, *Arlington*
Florentino, Paul F, *Alexandria*
Fluharty, David G Jr, *Newport News*
Foreman, David Ross, *Suffolk*
Forestiere, Joseph, *Virginia Beach*
Forgosh, Les Bryan, *Viriginia Beach*
Fornaris, Ernest A, *Richmond*
Fortune, Thomas Patrick, *Alexandria*
Fosko, Scott William, *Charlottesville*
Foster, Harriet Hutto, *Richmond*
Foster, Harry C Jr, *Martinsville*
Foster, James Daniel, *Richmond*
Foulke, Charles W, *McLean*
Fowler, Alpha A III, *Midlothian*
Fozdar, Pratima Singh, *Alexandria*
Francis, Vernon Raphael, *Hampton*
Franklin, John, *Norfolk*
Franklin, William A Jr, *Newport News*
Franklin, William George, *Arlington*
Franks, Paul E, *Richmond*
Freund, Jack, *Richmond*
Friehling, Ted David, *Alexandria*
Froede, Craig Brian, *Virginia Beach*
Froggatt, John Wesley III, *Richmond*
Fronc, Henry Conrad Jr, *South Hill*
Frutchey, John Alexander, *Roanoke*
Fu, Shu-Man, *Charlottesville*
Fuhs, Bryan Edward, *Richmond*
Fuller, Peggy Anita, *Chesapeake*
Fuller, Philip Stuart, *Fredericksburg*
Funk, Janet Lorraine, *Arlington*
Furman, Stanley N, *Richmond*
Fussell, James David, *Virginia Beach*
Gab-Allah, Thonia Hafez, *McLean*
Gaines, Ronald Lynn, *Roanoke*

Internal Medicine *(cont'd)*

Galeski, Joseph III, *Richmond*
Galetto, David Wayne, *Hampton*
Galishoff, Mitchel L, *Glen Allen*
Gallagher, Edward J, *Fairfax*
Gallinek, Wilfred Ernest, *Arlington*
Gamsey, Alan Jay, *Norfolk*
Ganderson, Alan P, *Virginia Beach*
Garcia, Joseph, *Chesapeake*
Garcia, Stephen E, *Richmond*
Gardiner, James E, *Winchester*
Gardner, Allen Stiles, *Springfield*
Gardner, Amy Louise, *Troy*
Gardner, Clay T Jr, *Richmond*
Gardner, David F, *Richmond*
Gardner, Rufus S Jr, *Staunton*
Garner, Dorothy Caroline, *Roanoke*
Garnett, Alfred Randolph, *Richmond*
Garrett, Algin B, *Richmond*
Garris, Sheila Y, *Norfolk*
Garris-Wallace, Sheila, *Richmond*
Garzon, Fernando Luis, *Marion*
Gasperetti, Christine Maria, *Charlottesville*
Gates, Beverly Diane, *Richmond*
Gavora, Les Hugh, *Springfield*
Gavrilovich, Lillian, *McLean*
Gaydos, Lawrence Alfred, *Annandale*
Gayer, Karla Dorothy, *Alexandria*
Gayle, Sigsby Warren, *Richmond*
Gehring, David William, *Alexandria*
Gelfman, Daniel Mark, *Falls Church*
Gelrud, Louis Gerald, *Richmond*
Gemma, Nicholas William, *Charlottesville*
Geoly, Kenneth Lucian, *Fairfax*
Georges, Theodore Nickolas, *Norfolk*
Germroth, Jerry Alan, *Edinburg*
Ghaemmaghami, Nosratollah, *Arlington*
Gibert, Cynthia Livingstone, *McLean*
Gibson, Kim Fricke, *Virginia Beach*
Gibson, Robert S, *Charlottesville*
Gibson, Sandy Morton, *Arlington*
Gidney, Elizabeth M, *Richmond*
Giesen, John W, *Radford*
Giessel, Glenn M, *Richmond*
Gilbert, Charles Louis, *Doswell*
Giles, Richard D, *Lynchburg*
Gill, Joseph Patrick, *Richmond*
Gilliland, Charles D, *Roanoke*
Gilmore, Bruce Leslie, *Alexandria*
Ginsberg, Gregory Gerard, *Reston*
Giordano, Joan, *Norfolk*
Giroux, Arthur Steven, *Virginia Beach*
Givens, Curtis Delp Jr, *Newport News*
Glenn, Robert Lee, *Lynchburg*
Glessner, Steven Frederick, *Kilmarnock*
Glickman, Lee Mitchell, *McLean*
Glickman, Penny Sue, *Richmond*
Glocheski, Susan Kay, *Richmond*
Glontz, Gary Edwin, *Roanoke*
Gnatt, Michael A, *Arlington*
Gofreed, Deborah Lynne, *Arlington*
Goins, Ernest Earl, *Suffolk*
Goldberg, Jay Stephen, *Colonial Heights*
Goldberg, Marvin, *Norfolk*
Goldberger, Mark Jay, *Springfield*
Goldman, Charles Jay, *Norfolk*
Goldsman, Helene, *Richmond*
Goldstein, Alben G, *Falls Church*
Goldstein, Stafford S, *Arlington*
Gomez, Lucia, *McLean*
Gonzaga, Rufina Cruz, *Virginia Beach*
Gonzales, F Carlos, *Fairfax*
Gonzalez, Nelida A, *Reston*
Gonzalez, Ulysses S, *Wise*
Gooding, James J, *Roanoke*
Goodman, Peter Lewis, *Richmond*
Goodman, Robert P, *Richmond*
Gorcsan, John, *Glen Allen*
Gorsuch, Thomas L, *Waynesboro*
Goss, Larry Zane, *Charlottesville*
Gottimukkala, Maruthi Varaprasad, *Virginia Beach*
Goudreau, Evelyne, *Richmond*
Goulah, Richard Daniel, *South Boston*
Grabowy, Thaddeus John, *Arlington Va*
Graham, Susan Perkins, *Richmond*
Gramlich, Martha P, *Alexandria*
Grant, Kenneth D, *Oakton*
Grant, Steven, *Richmond*
Graves, Jeffrey Mershon, *Norfolk*
Grayson, George I, *Virginia Beach*
Green, Gary Lee, *Sterling*
Green, Harold T Jr, *Richmond*
Green, Melvin G Jr, *Newport News*
Green, Robert Castleman Jr, *Winchester*
Greenberg, David J, *Richmond*
Greenberg, M Taylor, *Hampton*
Greene, Michael David, *Arlington*
Greenspan, Robert E, *Fairfax*
Greenwald, Todd Paul, *Charlottesville*
Gress, Jeffrey Paul, *Arlington*
Gretes, John C, *Newport News*
Grier, George S III, *Newport News*
Griggs, George Albert, *Hampton*
Grimes, Jeffery Robert, *Roanoke*
Grinnan, William C, *Richmond*
Griswold, Martha A, *Petersburg*
Grollman, Evelyn F, *McLean*
Groopman, David S, *Richmond*
Grosh, William Wangerin Sr, *Charlottesville*
Gross, Frederick M Jr, *McLean*
Grove, Lucian Yates Jr, *Salem*
Grover, William Howell, *Lynchburg*
Grubbs, Earl Alwin, *Virginia Beach*
Grulke, David C, *Norfolk*
Gruver, Robert H, *Arlington*
Guerrant, John L, *Charlottesville*
Guerrant, Richard L, *Charlottesville*
Guillaudeu, Robert L, *McLean*
Gunzenhaeuser, Leslie F, *Roanoke*
Gupta, Ambrish Kumar, *Alexandria*
Gupta, Jyotsna, *McLean*
Gupta, Kamlesh, *McLean*
Gurney, Ronald E, *McLean*
Guthrow, Clyde Earl Jr, *Lynchburg*
Gutierrez, Miguela T, *Williamsburg*
Guynn, Cyrus Harding, *Springfield*
Guzelian, Philip S Jr, *Richmond*
Gwaltney, Jack M Jr, *Charlottesville*
Gyorfi, Peter, *McLean*
Haden, Halcott T, *Richmond*
Haerr, Robert William, *Chesapeake*
Hahn, Gunter Ernst, *Manassas*
Hahn, Stephen Michael, *Great Falls*
Haines, David Emens, *Charlottesville*
Haithcock, Roderick E, *Richmond*
Hake, Gerald William, *Sandston*
Hakim, Christopher Adnam, *Newport News*
Haley, Elliott C Jr, *Charlottesville*
Halfond, Ivan, *Centreville*
Hall, Aubrey Carlyle, *Clifton Forge*
Hall, Dennis McCoy, *Roanoke*
Hall, Ralph Arthur, *Barboursville*
Hall, Sherry Lene, *Woodbridge*
Hall, Snowden C III, *Staunton*
Hallal, Fadell Joseph, *Annandale*
Halloran, Randolph M, *Richmond*
Ham, Tibor John Jr, *Vienna*
Hamill, Carroll F, *Reedville*
Hammond, William, *Charlottesville*
Hamrick, John D, *Williamsburg*
Han, Jiho Joseph, *Richmond*
Hancock, Mark Robert, *Richmond*
Hancock, William Joseph, *Winchester*
Handy, Richard Davis, *Portsmouth*
Hanger, Keith Elwood, *Williamsburg*
Hanley, Robert Hayes Jr, *Ashland*
Hanna, Constance Rickard, *Richmond*
Hannah, Brian Alexander, *Arlington*
Harden, William Boyd, *Bluefield*
Harding, Robert Ralph, *Charlottesville*
Harler, John Ashby Sr, *Richmond*
Harper, Lisa, *Annandale*
Harr, George Charles, *Virginia Beach*
Harrigan, Richard Allen, *Richmond*
Harris, Norman Stuart, *Lynchburg*
Harris, William Henry Jr, *Richmond*
Harris, William Wallace Jr, *Salem*
Harrow, Arthur S, *Richmond*
Harry, Frederick P, *Colonial Heights*
Hart, Richard Joseph Jr, *Falls Church*
Hartman, Mark Leopold, *Charlottesville*
Harvie, Edwin James, *Danville*
Hasko, Barbara Ann, *Fairfax*
Hassan, Zubair Ul, *Richmond*
Hassett, Margaret Alycia, *Arlington*
Hastillo, Andrea, *Midlothian*
Hatala, John Vincent, *Alexandria*
Hatcher, James J, *Virginia Beach*
Hattwick, Michael A, *Annandale*
Haun, Jacob Jr, *Woodstock*
Haut, Donald David, *Alexandria*
Hawkins, Richard Eric, *Norfolk*
Hawkins, Richard F, *Lynchburg*
Hawkins-Gustin, Katherine R, *Winchester*
Hawthorne, Harry Robert, *Richmond*
Hayden, Frederick G, *Charlottesville*
Hayes, John Charles, *Roanoke*
Hecht, Alan, *Midlothian*
Hecht, Gary Michael, *Norfolk*
Heck, Albert William, *Charlottesville*
Hefner, Charles A, *Roanoke*
Heide, Robert Kay, *Norfolk*
Heinen, Robert John, *Alexandria*
Heit, Howard A, *Fairfax*
Helbert, Hollen G, *Broadway*
Helm, W Jackson, *Winchester*
Henley, Robert W Jr, *Richmond*
Hennelly, Patrick Joseph, *Norfolk*
Henry, Ann Katherine, *Waynesboro*
Henry, Reginald B Jr, *Norfolk*
Henry, Reginald Buchanan III, *Norfolk*
Herbert, Anita J, *Springfield*

Internal Medicine *(cont'd)*

Herre, John Milton, *Norfolk*
Herrick, Timothy Wright, *Arlington*
Hess, James Brock, *Williamsburg*
Hess, Michael L, *Richmond*
Hicks, Charles Byron, *McLean*
Hicks, John T, *Arlington*
Higgins, Michael R, *Norfolk*
Higgins, William H Jr, *Richmond*
Hiles, Charles H Jr, *Roanoke*
Hill, Douglass Orville, *Winchester*
Hill, Elizabeth Harman, *Vienna*
Hillner, Bruce Ellis, *Richmond*
Himes, Richard Singer, *Williamsburg*
Himmelreich, Lester Leon, *Portsmouth*
Hines, Susan Jean, *Richmond*
Hipol, Rosario D, *Virginia Beach*
Hite, Robert Duncan, *Charlottesville*
Hodeen, Eric Carleton, *Norfolk*
Hodge, E Beaumont Jr, *Norfolk*
Hodge, Robert Henry Jr, *Charlottesville*
Hoerner, Kathleen Margaret, *Middleburg*
Hoffler, Richard Winfred Jr, *Norfolk*
Hoffler, William M Jr, *Norfolk*
Hoffman, Charles J, *Chesapeake*
Hoffman, Richard S, *Norfolk*
Hoffmier, Thomas J, *Williamsburg*
Holland, Ralph Duane, *Galax*
Holliman, Daniel Rhodes, *Radford*
Hollis, Joseph Boniface, *Portsmouth*
Holsinger, Donald Rider, *Martinsville*
Holt, Mark Edgar Jr, *Portsmouth*
Hook, Edward W Jr, *Charlottesville*
Hopkins, Scott Joel, *Falls Church*
Horenstein, Martin, *Richmond*
Hormel, Barbara Ann C, *Roanoke*
Horne, McDonald K III, *Alexandria*
Horne, Melvin L, *Virginia Beach*
Hortenstine, John C, *Winchester*
Horton-Marcella, Jane Tracy, *Lexington*
Hovland, William N, *Norfolk*
Howard, Catherine, *Richmond*
Howard, Lawrence Max, *Lynchburg*
Howard, Walter Wesley, *Charlottesville*
Howe, Craig W S, *Richmond*
Howell, Hannibal Eldredge, *Hampton*
Howlett, Stephen Andrew, *Waynesboro*
Hoyme, Jane C, *Arlington*
Hoyt, Robert Eugene, *Kilmarnock*
Huber, Charles Mac, *Front Royal*
Huber, Elizabeth Claire, *Richmond*
Hudson, Sue Beth, *Virginia Beach*
Hughes, Kenneth Robert, *Cana*
Hunt, Lillian B, *Arlington*
Hunter, Thomas Harrison, *Keswick*
Huntley, Benjamin F, *Huddleston*
Huppi, Joan Waldron, *Reston*
Hutcheson, Jack Robert Jr, *Roanoke*
Hutcheson, Robert Jr, *Roanoke*
Hyatt, Kenneth H, *Norfolk*
Hyun, Chul Soo, *McLean*
Iatridis, Angelos, *Richmond*
Ibarra, Irene F, *Roanoke*
Ibrahim, Hassan Mohammad, *Richmond*
Ilano, Yolanda R, *Marion*
Illango, Ramanathan K, *Midlothian*
Immerman, Richard Philip, *Alexandria*
Infeld, Donald Samuel, *Great Falls*
Irani, Furadoon Adi, *Front Royal*
Iranmanesh, Ali, *Salem*
Irwin, Gilbert Raymond, *Manassas*
Islam, Mohammad Aminul, *Portsmouth*
Jaber, Peter William, *Charlottesville*
Jackson, Horace Jake, *Richmond*
Jackson, Larry Kent, *Reston*
Jackson, Richard A, *Richmond*
Jacobson, Abraham M, *Roanoke*
Jacobson, Eric S, *Richmond*
Jacoby, William J Jr, *Williamsburg*
Jadhav, Gopinath Rao, *Petersburg*
Jain, Rajiv, *Roanoke*
Jalla, Girja R, *Arlington*
Jamaludeen, Abdul Hamid, *Hampton*
James, G Watson III, *Richmond*
James, George W IV, *Richmond*
James, Thomas III, *Norfolk*
Janney, Samuel M II, *Mechanicsville*
Jarbadan, Ignaz Papa, *Woodbridge*
Jastrzebski, George Witold, *Reston*
Javed, Muhammad R, *Richlands*
Jenkins, C Mitchell, *Virginia Beach*
Jenkins, John Kenneth, *Richmond*
Jennings, C Foster Jr, *Richmond*
Jennings, Robert Hutchings, *Charlottesville*
Jensen, Edward Walter, *Chester*
Jesse, Robert Louis, *Richmond*
Jessee, Edgar F Jr, *Richmond*
Jimenez, Jesus G, *Arlington*
Joaquino, Jorge Borces, *Virginia Beach*
Jofko, John, *Roanoke*
Johns, Mark Edward, *Chesterfield*
Johnson, Betty Anne, *Richmond*
Johnson, Bruce E, *Virginia Beach*
Johnson, Charles, *Ewing*
Johnson, Danna Elizabeth, *Glen Allen*
Johnson, Earl Robert, *Roanoke*
Johnson, Josette Jacqueline, *Reston*
Johnson, Melvin R, *Hampton*
Johnson, Richard B Jr, *Norfolk*
Johnson, Robert Alexander, *Colonial Heights*
Johnson, Robert Riley, *Richmond*
Johnson, Sandra Stumbaugh, *Hampton*
Johnson, Stephen M, *Lynchburg*
Johnston, Mark Harold, *Virginia Beach*
Jones, Cheryl F, *Chesterfield*
Jones, Harold Decomus III, *Gloucester*
Jones, John Paul, *Hampton*
Jones, Judith Karen, *McLean*
Jones, Mark David, *Arlington*
Joseph, Lerla Georgette, *Richmond*
Joshi, Vasudha V, *Reston*
Joshua, Alan, *Reston*
Joslyn, Emerson Allen, *Bedford*
Julka, Sudhir Kumar, *Alexandria*
Jurko, Robert Michael, *Chesapeake*
Kahn, Howard Donald, *Richmond*
Kaiser, John R, *Williamsburg*
Kakaviatos, Nikos, *Arlington*
Kalbian, Vicken Vahan, *Winchester*
Kanwal, Gurcharan Singh, *Coeburn*
Kanwal, Neeraj Kumar, *Alexandria*
Kapadia, Pradipchandra B, *Appalachia*
Kaplan, Arthur Sanford, *Norfolk*
Kaplan, Craig Bennett, *Richmond*
Kaplowitz, Lisa G, *Richmond*
Karagounis, Labros Andreas, *Roanoke*
Karan, Lori Deene, *Richmond*
Karas, Steven Peter, *Arlington*
Karim, Mobarak, *Springfield*
Katusha, Kathy, *Arlington*
Katz, Edward Neil, *Richmond*
Katz, Ernest III, *Springfield*
Kaufmann, Lucina G, *Alexandria*
Kaufmann, Reto Werner, *Reston*
Kawecki, Janet K, *Alexandria*
Kay, George Gordon, *Fairfax*
Kay, William Richard, *Richmond*
Kaye, Zachary A, *Woodbridge*
Kazlow, Gary Alan, *Norfolk*
Keeling, Richard Powell, *Charlottesville*
Keenan, Grace Lillian, *Sterling*
Kellam, Lloyd Joseph III, *Nassawadox*
Kellam, Marilyn Schneider, *Nassawadox*
Keller, Mark Ward, *Charlottesville*
Kelley, Georgia Ann, *Richmond*
Kelly, Adrianne P, *Annandalen*
Kelly, David Louis, *Bowling Green*
Kelly, Frank Robert Jr, *Richmond*
Kelly, John Jackson III, *Richmond*
Kelly, Kathleen Mary, *Springfield*
Kendall, Martha, *McLean*
Kennedy, Carol Elizabeth, *Fairfax*
Kennedy, Jerry Ray, *McLean*
Kenny, Eric Richard, *Chesterfield*
Kerkering, Thomas Michael, *Richmond*
Kerr, Herbert H, *Markham*
Kessler, Charles A, *Norfolk*
Kessler, Ellen R, *Springfield*
Key, Wendell Wayne Jr, *Richmond*
Khan, Mohammad Aqiq, *Burke*
Kiamko, Rosario T, *Norfolk*
Kicklighter, Elizabeth Jane, *Alexandria*
Kilfeather, John E, *Fairfax*
Kim, Heeshin, *Woodbridge*
Kim, Myung Woong, *Hampton*
Kim, Taeho, *Fallls Church*
King, Anne L, *Doswell*
King, C Sidney, *Lynchburg*
Kingree, William B, *Edinburg*
Kipreos, Theophilos H, *Richmond*
Kirby, Donald Francis, *Richmond*
Kirkland, Lisa Lee, *Richmond*
Kirschbaum, Barry B, *Richmond*
Kisa, Erik Harold, *Virginia Beach*
Kiselica, Daria, *Charlottesville*
Kiss, Stephen Clement, *Richmond*
Klein, Arthur, *Richmond*
Klein, Jonathan, *Falls Church*
Knarr, John Weidner, *Pulaski*
Knight, Herbert, *Charlottesville*
Knight, James G, *Charlottesville*
Knitter, David Scott, *Troutville*
Knoll, Diane Ramus, *Richmond*
Knowlan, Donald M, *Fairfax*
Knowles, Scott E, *Colonial Heights*
Koehler, Rolf Alfred, *Fairfax*
Koh, Woon Hi, *Hampton*
Kohler, Stewart Edwin, *Fredericksburg*
Kokich, Rudy Emil, *Franklin*
Kollar, Kevin Theodore, *Charlottesville*
Kolmstetter, Siegfried Joseph, *Roanoke*
Koplen, Julian Arthur, *Danville*
Kornetsky, Kenneth M, *Warrenton*

Internal Medicine *(cont'd)*

Kornhauser, Michael James, *Falls Church*
Kory, Ross Conklin, *Arlington*
Koslow, Joel Lester, *Alexandria*
Kot, Peter A, *Fairfax*
Koul, Moti L, *Fairfax*
Kozlow, Eric Jon, *Richmond*
Krajina, Alexander Anthony, *Richmond*
Kramer, Celia A, *Annandale*
Kraus, Shane J, *Quinton*
Kress, Scheldon Jr, *Springfield*
Krishnamurthy, Kalale S, *Petersburg*
Kroll, Ronald N, *Richmond*
Kruithoff, Wayne Allan, *Norfolk*
Krup, Jennifer F, *Virginia Beach*
Krystal, Geoffrey Wolfe, *Richmond*
Kucera, Jon Carrell, *Richmond*
Kumar, K L Ashok, *Chester*
Kumar, Medicherla Shyamsunder, *Richmond*
Kurz, Otto A, *Falls Church*
Kussman, Michael James, *Burke*
Kuta, Arnold John, *Quinton*
La Rocca, Renato Vincenzo, *Sterling*
La Rocque, James Calvin, *Portsmouth*
Lacey, John Robert, *Newport News*
Lacy, Edgar W Jr, *Winchester*
Lafsky, Robert D, *Leesburg*
Lahti, Corrine Elizabeth, *Burke*
Lambdin, James W, *Franklin*
Lamberti, James Paul, *Falls Church*
Lando, Howard M, *Reston*
Larner, James Mitchell, *Charlottesville*
Lastinger, Len B Jr, *Galax*
Latham, Wiley Jacob, *Richmond*
Laughlin, Carl Patrick, *Newport News*
Law, Charles E Sr, *Alexandria*
Lawford, Thomas C, *Newport News*
Laws, Allen Maurice, *Galax*
Leake, Andrew Kean III, *Hampton*
Leddy, Anne Lucia, *Newport News*
Lee, Alfred, *Chesterfield*
Lee, Thomas H, *Charlottesville*
Lee, Uk Ho, *Burke*
Legrow, Wynne V E, *Emporia*
Le Hew, Allen Edwin, *Clifton Forge*
Leibowitz, Beth Jan, *Portsmouth*
Leichtman, Alan Bertram, *Norfolk*
Lemly-Mundy, Regina Gail, *Norfolk*
Lemmer, Joseph P, *Salem*
Lerman, Martin S, *Reston*
Leskovec, William Conrad, *Norfolk*
Leslie, Catherine Alexandra, *Charlottesville*
Lessin, Bruce Edward, *McLean*
Levey, Myron S, *Salem*
Levin, Leonard L, *Richmond*
Levin, Norman William, *Manassas*
Levine, Michael Daniel, *Alexandria*
Levine, Robert Scott, *Alexandria*
Levit, Peter D, *Alexandria*
Levy, Edward David, *Norfolk*
Levy, James Robert, *Richmond*
Levy, Warren Seth, *Arlington*
Levy, William Joel, *Arlington*
Lewin, Lucas D, *Nassawadox*
Lewis, W Benton, *Martinsville*
Lidman, Roger William, *Virginia Beach*
Ligeti, Marianne B, *Arlington*
Lillis, Frederick P, *Leesburg*
Lim, Angelita A, *Virginia Beach*
Lindbeck, George Harris, *Charlottesville*
Lindsey, Stephen M, *Virginia Beach*
Link, Kurt, *Richmond*
Lipskis, Donald J, *Norfolk*
Littleton, Frederick Charles N Jr, *Kilmarnock*
Littman, Bruce H, *Richmond*
Liu, Jing Win, *Salem*
Liu, Ying-Ying, *Norfolk*
Lizarralde, German, *Salem*
Loesch, Beverly Jean, *Waynesboro*
Loftin, Charles Ivey III, *Roanoke*
Lombana, Alfonso, *Farmville*
Long, James A, *Waynesboro*
Longacher, Joseph W Jr, *Richmond*
Lopez, Emigdio A Jr, *Springfield*
Lorimer, William V, *Chatham*
Lotz, Myron, *Arlington*
Lowen, Beal Aptheker, *Alexandria*
Lowry, Philip Andrew, *Charlottesville*
Lubin, Barry C, *Norfolk*
Lucas, Robin S, *Falls Church*
Luketic, Velimir Anthony, *Richmond*
Lukowsky, Gerhard Hans, *Alexandria*
Lumpkin, Martha R, *Arlington*
Luna, Federico M, *Norfolk*
Lundberg, Doris, *Woodbridge*
Lupton, Bruce Barry, *The Plains*
Lydon, John P, *Midlothian*
Lynch, Sean Roborg, *Yorktown*
Lynn, Dorcas J, *Clifton*
Lyons, Karen Ann, *Lexington*
Mac Ilwaine, William A, *Waynesboro*
Mac Kinnon, Roderick Russell, *Chesapeake*
Maccubbin, Harry P, *Kinsale*
Machan, James Robert, *Fredericksburg*
Magnant, Charles D, *Doswell*
Magnin, Albert Jr, *Chester*
Magpoc, Norma O, *Virginia Beach*
Mahoney, Michael Dennis, *Virginia Beach*
Maine, Charles P, *Norton*
Major, Mary Jane, *Arlington*
Makipour, Houshang, *McLean*
Malakoff, Gary Lee, *Great Falls*
Malloy, Walter N, *Tappahannock*
Maloney, William James, *Charlottesville*
Malpani, Kalidas Damodar, *Arlington*
Malpass, Michael A, *Roanoke*
Mamana, John Philip, *Springfield*
Manalaysay, Alvin Rene, *Chantilly*
Manalo, Bayani L, *Falls Church*
Manalo, Buenaventura Jr, *Salem*
Mandel, Michael David, *Richmond*
Mandell, Gerald Lee, *Charlottesville*
Mandelstamm, Maria T, *Blacksburg*
Mandes, Thomas C, *Vienna*
Manetta, Evelyn Walker, *Roanoke*
Mangus, Samuel J, *Yorktown*
Manickavasagar, Marie A, *Chesapeake*
Mann, Jatinder Pal Singh, *Dale City*
Mann, Robert Fletcher, *Norfolk*
Manser, Thomas, *Norfolk*
Marcellin, Lindsey Newcome, *Sterling*
Margolius, Alvin Jr, *Norfolk*
Markham, J David, *Richmond*
Markowitz, Michael Paul, *Glen Allen*
Markowitz, Sheldon Michael, *Richmond*
Marks, Charles Wesley, *Virginia Beach*
Marks, Frank Wayland, *Fredericksburg*
Marri, Ramalakshmi Nma, *Charlottesville*
Marshall, Timothy L, *Virginia Beach*
Martens, Werner Jr, *Norfolk*
Martin, Trent Douglas, *Virginia Beach*
Martin, William Watkins, *Richmond*
Martino, Alberto N, *Alexandria*
Mascarinas, Teofilo Cano, *Virginia Beach*
Mason, James D Jr, *Petersburg*
Massey, John William Jr, *Newport News*
Massey, William Joseph III, *Williamsburg*
Massie, William McKinnon, *Lynchburg*
Mathews, Emmett C, *Richmond*
Mathews, John Joseph Jr, *Burke*
Matias, Esther M, *Alexandria*
Matthews, James Harvey, *Richmond*
Mattson, Melanie Danielle, *Norfolk*
Maturi, Martha Marie, *Vienna*
Maturi, Mary Frances, *Virginia Beach*
Mauroner, Norman Lee Jr, *Warrenton*
Maw, Khin Thet, *Falls Church*
Mayhall, C Glen, *Richmond*
Mc Cabe, Thomas Ambrose, *Arlington*
Mc Callum, Richard Warwick, *Charlottesville*
Mc Cauley Henry, Deborah, *Virginia Beach*
Mc Clanahan, Mark Allen, *Richmond*
Mc Clatchey, Scott Kevin, *Fairfax*
Mc Clellan, Jason E, *Newport News*
Mc Clure, William W, *Arlington*
Mc Conahey, William M III, *South Boston*
Mc Cone, Jonathan, *Alexandria*
Mc Connell, James J, *Wytheville*
Mc Corkle, Robert Leroy, *Tappahannock*
Mc Cormack, Regina Claire, *Charlottesville*
Mc Coy, Glenora Cook, *Falls Church*
Mc Cue, Howard M Jr, *Richmond*
Mc Curdy, Paul R, *Alexandria*
Mc Daniel, James Lund, *Nassawadox*
Mc Dermott, Annette Marie, *Waynesboro*
Mc Dermott, Glenn Robert, *Virginia Beach*
Mc Donald, David B, *Fairfax*
Mc Entee, Kathleen Peplinski, *Chesapeake*
Mc Gowan, John A, *Harrisonburg*
Mc Groarty, David J, *Richmond*
Mc Henry, Lee Jr, *Richmond*
Mc Kenzie, Diane Florence, *Annandale*
Mc Kinley, William Oscar, *Richmond*
Mc Leod, David Allen, *Richmond*
Mc Manus, Patrick J, *Fredericksburg*
Mc Manus, Reginald Paul, *Springfield*
Mc Master, John D, *Alexandria*
Mc Murtry, Cynthia Thomas, *Richmond*
Mc Pherson, Lon Helton, *Winchester*
Mc Pherson, Milton Lee, *South Boston*
Mc Queen, Robert Clarkson, *Winchester*
Mechanick, Judith, *Oakton*
Medford, Frank E, *Newport News*
Medoff, Neil F, *Reston*
Mellette, Susan J, *Richmond*
Melville, Kirk Alan, *Jonesville*
Menasha, Moussa Youssef, *Suffolk*
Mendlow, Stephanie, *Madison*
Mercer, Angela Myra, *Norfolk*

Internal Medicine *(cont'd)*

Meredith, H Clarkson Jr, *Norfolk*
Merlino, Robin Beth, *Springfield*
Meyer, Gregory McBride, *Virginia Beach*
Meyerhoff, George Edward, *Richmond*
Meyers, Stuart A, *Alexandria*
Micale, Paul Joseph, *Newport News*
Michalski, Martha Caroline, *Hume*
Miles, Nancy Rebecca, *Tazewell*
Miller, Bernard H, *Chesapeake*
Miller, Carlton Edwin, *Richmond*
Miller, David S II, *Salem*
Miller, Edward C, *Norfolk*
Miller, Grayson Brownlee Jr, *Richmond*
Miller, Jeffrey Scott, *Richmond*
Miller, Jess P, *Hampton*
Miller, John Milton, *Roanoke*
Miller, Jonathan W, *Norfolk*
Miller, Karen Sue, *Roanoke*
Miller, Lawrence Allan, *Alexandria*
Miller, Mary Irene, *Woodstock*
Miller, Michael Jeffrey, *Richmond*
Miller, Scott Arnold, *Norfolk*
Mills, Robert J, *Falls Church*
Milteer, Warren E, *Suffolk*
Mincks, John Charles, *Williamsburg*
Minisi, Anthony Joseph, *Richmond*
Mishra, Raj Kumar, *Chesterfield*
Miskovsky, Emil Peter, *Arlington*
Mistry, Zarine, *Portsmouth*
Mitchell, Ellen Kay Angle, *Richmond*
Mitchell, Robert E Jr, *Richmond*
Mitchell, William Craig, *Roanoke*
Mittal, Ravinder Kumar, *Charlottesville*
Moffatt, Thomas Lee, *Richmond*
Mohanty, Pramod Kumar, *Richmond*
Moir, William Maryon, *Roanoke*
Molina, Manuel J, *Hampton*
Molony, Patrick A, *Pennington Gap*
Monahan, Lawrence Keith, *Roanoke*
Monroe, Sara Gottlieb, *Richmond*
Montalbano, Foster R, *Alexandria*
Moody, Wanda Rene, *Newport News*
Moore, Laurie W Jr, *Hampton*
Moore, Marianne, *Arlington*
Moore, Michael Judson, *Roanoke*
Moore, Ray A, *Farmville*
Moore, Robert P, *Richmond*
Moore, Susan Janet, *Charlottesville*
Morgan, Elma Adolphus Jr, *Portsmouth*
Moriarty, Michael John, *Richmond*
Morillo, Segundo Antonio, *Falls Church*
Morjaria, Mukund M, *Falls Church*
Morris, Gordon Leigh, *Charlottesville*
Morrison, John C, *Salem*
Morrissey, William F, *Arlington*
Morrow, Calvin F Jr, *Hampton*
Morton, Robert A, *Norfolk*
Mosca, Alfon Bernard, *Charlottesville*
Moses, Gail Anne, *Norfolk*
Moss, Lloyd F, *Fredericksburg*
Mott, Howard O, *Falls Church*
Mousavi, Morteza Seied, *McLean*
Moussalli, Clarice, *Richmond*
Moussalli, Colette, *Richmond*
Moxley, George F, *Richmond*
Moylan, Robert Daniel, *Charlottesville*
Muczynski, Kimberly Ann, *Arlington*
Muenzen, Christopher Paul, *Springfield*
Muir, W Angus, *Fredericksburg*
Mujeebuddin, Mohammad, *Chester*
Mullen, Jewel M, *Charlottesville*
Mulligan, Thomas Michael, *Powhatan*
Mullinax, Perry Franklin, *Richmond*
Munzel, Thomas L, *Williamsburg*
Muren, Orhan, *Richmond*
Murow, Raymond J, *Springfield*
Murphy, Dennis Richard, *Arlington*
Murray, Kevin Patrick, *Norfolk*
Myaing, Alfred Chit, *Alexandria*
Myers, Lyle Christopher, *Chesapeake*
Nachnani, Gurbux H, *Alexandria*
Nadler, Joel Bruce, *Alexandria*
Nagula, Seetaramayya, *Alexandria*
Nalls, Walter L, *Boyce*
Nance, Walter E, *Richmond*
Nancherla, Suchithra Ananth, *McLean*
Narla, Shireesha Natwa, *Richmond*
Nashel, David Joel, *McLean*
Nassiri, Saeed K, *Richmond*
Nath, Amar, *Richmond*
Navid, Ebrahim, *Arlington*
Naylor, William Talbott, *Norfolk*
Nazzal, Jenny Jamileh, *Annandale*
Neal, John J Jr, *Danville*
Neathawk, Jacob P Jr, *Salem*
Neely, Eileen Purcell, *Richmond*
Nehra, Archna, *Vienna*
Nelson, Kinloch, *Richmond*
Nestler, John E, *Richmond*
Newsome, Bobbette E, *Richmond*
Newsome, Glenn Stuart, *Vienna*
Newton, David Alan, *Radford*
Newton, Grace Ann Southard, *Charlottesville*
Nguyen, Phong Quang, *Springfield*
Nguyen, Quan Q, *Annandale*
Nguyen, Tu Huu, *Midlothian*
Nguyen-Dinh, Thanh, *Arlington*
Nicholson, Dorothy Mary, *Alexandria*
Nielsen, Peter E, *Flint Hill*
Nixon, John Victor, *Richmond*
Noel, Roger A, *Annandale*
Noland, Eugene B Jr, *Roanoke*
Nottingham, Maurice Jr, *Richmond*
Nsien, Ephraim Emmanuel, *Alexandria*
Nuara, Joseph Carl, *Richmond*
Nuckolls, James G, *Galax*
Nunez, Bernard Emilio, *Castleton*
Nussbaum, Lawrence Lee, *Harrisonburg*
Nye, Glenn Carlyle, *Norfolk*
Oberlender, Gary Harvey, *Salem*
O'Brien, Thomas E, *Falls Church*
Obsusin, Alisa Nan, *Norfolk*
O'Donnell, Philip J, *Winchester*
Oken, Donald E, *Richmond*
Old, Wayne David, *Richmond*
Oliphant, Beverly Ann, *Annandale*
Olson, Paul Alan, *Pearisburg*
Ooghe, Robert B, *Charlottesville*
Oppleman, Leslie Barri, *Norfolk*
Opritza, Gregory Dean, *Alexander*
Orban, Leonard Baily, *Portsmouth*
Ordonez, Priscilla A, *Virginia Beach*
Ornato, Joseph Pasquale, *Richmond*
Osheroff, Raphael Joseph, *Alexandria*
Oufiero, Lawrence A, *Fairfax Station*
Overmeyer, Richard L, *Mechanicsville*
Ozinal, Hasan Gungor, *Waynesboro*
Ozinal, Ulku, *Waynesboro*
Ozols, Robert Felix, *Great Falls*
Pacharzina Powers, Linda, *Richmond*
Pade, Patricia Ann, *Williamsburg*
Page, Lourdes Maria, *Roanoke*
Page, Paul Fielding, *Roanoke*
Pagliaro, Lance Christopher, *Alexandria*
Paine, Robert E Jr, *Salem*
Painter, Jack Allan, *Richmond*
Paluch, Simon III, *Springfield*
Pambianco, Daniel John, *Charlottesville*
Pambid, Leovigil D, *South Boston*
Pancoast, Sharon Ann Putnam, *Richmond*
Pandak, William Michael Jr, *Richmond*
Pandya, Bhushan Hiralal, *Danville*
Panigrahi, Gunadhar, *Virginia Beach*
Pannell, Tammy Elizabeth, *Mechanicsville*
Paranthaman, Subramaniam, *Appalachia*
Parente, Antonio Rocco, *Alexandria*
Park, Ralph S Jr, *Staunton*
Park, Soo Woong, *Fairfax*
Parker, Clifton L, *Richmond*
Parks, Joy A, *Richmond*
Parrish, Alvin E, *McLean*
Parrott, Marian A, *McLean*
Parry, Gwilym, *Reston*
Paschal, James Richard, *Norfolk*
Patel, Anilkumar Ravajibhai, *Virginia Beach*
Patel, Ashokkumar Ravjibhai, *Richmond*
Patel, Dinkar Nathabhia, *Grundy*
Patel, Thakor G, *Virginia Beach*
Patel, Tushar G, *Richlands*
Patrizio, John Anthony, *Richmond*
Patti, Mary-Elizabeth Rueckel, *Newport News*
Patton, Donnis Dee, *Charlottesville*
Paulsen, Walter H J, *Richmond*
Pavon, Humberto F, *Norfolk*
Payne, Jon M, *Blacksburg*
Peak, Daniel K Jr, *Franklin*
Pearce, Carney Cooper III, *Alexandria*
Pearson, Richard D, *Charlottesville*
Peltz, Edgar E, *Newport News*
Pendergrast, Kenneth Roy, *Chesterfield*
Pendleton, John W, *Roanoke*
Peng, Thomas Chih Cheng, *Midlothian*
Perel, Ludmila, *Hampton*
Perez, Justo T, *Richmond*
Perry, Robert P, *Richmond*
Peterson, Charles Hanson Jr, *Roanoke*
Pfoff, Robert Michael, *Big Stone Gap*
Pham, Khoi Duy, *Hampton*
Pham, Phu-Thu, *Springfield*
Philbrick, John T, *Charlottesville*
Phillips, Matthew, *Winchester*
Phillips, Thomas M, *Roanoke*
Phillips, Yancy Y, *Reston*
Piedra, Joaquin H, *Falls Church*
Pike, Irving M, *Virginia Beach*
Pippin, John J, *Richmond*
Pitman, Karen Tracy, *Chesapeake*
Pitts, Forrest Williford, *Richmond*
Pizzani, Eddy, *Richmond*
Planas-Galliano, Roque F, *Virginia Beach*

Internal Medicine *(cont'd)*

Platoff, Gennady E, *Fairfax*
Pleasants, Gregory James, *Richmond*
Poindexter, John S III, *Richmond*
Polk, William H, *Newport News*
Pollack, David, *Richmond*
Pollio, Francis Vincent, *Salem*
Pollock, Charles A Jr, *Richmond*
Pond, Trellou Joseph Jr, *Lynchburg*
Poses, Roy Maurice, *Richmond*
Posner, Robert Bruce, *Fairfax Station*
Poulton, Scott Craig, *Richmond*
Powers, Eric Randall, *Charlottesville*
Powers, Robert David, *Charlottesville*
Powers, William T, *Marion*
Price, Charles Daniel III, *Kilmarnock*
Price, Kathleen Newman, *Falls Church*
Prillaman, William W, *Radford*
Prince, Steven Ryland, *Norton*
Prince, W Daniel III, *Martinsville*
Proctor, Jack Douglas, *Richmond*
Propert, David B, *Norfolk*
Pruett, Timothy Lane, *Charlottesville*
Pudhorodsky, Gregory Stephen, *Charlottesville*
Pumarejo, Raymond Manuel, *Chesapeake*
Purdum, Preston Pemberton III, *Richmond*
Purohit, Girish, *Farmville*
Qazi, Naeem Akhrar, *Bluefield*
Quigg, Rebecca Jayne Hanna, *Midlothian*
Quinones, Moises Eladio, *Blacksburg*
Qureshi, Ghulam D, *Richmond*
Qureshi, Mashuq Ahmad, *Arlington*
Rafi, Esmail, *Fairfax*
Ragavan, Vanaja Vvijaya, *McLean*
Rahman, Rashida Khatoon, *Manassas*
Rakowski, Thomas Anthony, *Falls Church*
Raman, Ramesh, *Springfield*
Ramaswamy, Devanhalli, *McLean*
Ramey, Thomas Lee, *Richmond*
Ramirez-Muxo, Osvaldo, *Hampton*
Ramstad, David Scott, *Virginia Beach*
Rao, Bhaskar Gadahad, *Virginia Beach*
Rao, Sybil P, *Richmond*
Rassool, Mohammad, *Virginia Beach*
Ravdin, Jonathan I, *Charlottesville*
Rawles, James White Jr, *Virginia Beach*
Ray, Brenda Julia, *Richmond*
Rea, Edward L, *McLean*
Read, Charles Arthur, *Falls Church*
Ready, James McQuiddy, *Roanoke*
Reed, Carol Ruth, *Ashland*
Reed, Ernest C Jr, *Virginia Beach*
Reese, George Walter, *Richmond*
Reese, Kenneth Charles, *Richmond*
Regan, John Joseph, *Williamsburg*
Rehe, Gregory T, *Alexandria*
Rehr, Roger Bruce, *Midlothian*
Reid, James W Jr, *Newport News*
Reid, Judith Ellen, *Marion*
Reid, Robert Allen, *Charlottesville*
Reilley, Arthur Edward, *Annandale*
Reilly, Harold Francis, *Arlington*
Reilly, Michael Joseph, *McLean*
Rein, Michael Frank, *Charlottesville*
Rembold, Christopher Mark, *Charlottesville*
Remson, Anthony, *Roanoke*
Renaldo, Gary Joseph, *Richmond*
Renda, Paul V, *Norfolk*
Renfro, Thomas Edward, *Norton*
Repass, James Albert, *Richmond*
Reynolds, Robert Bruce, *Richmond*
Reynolds, Wayne Calvin, *Marion*
Rice, Doris M, *Chesapeake*
Rice, Marion L Jr, *Richmond*
Rice, Roselyn Joann, *Freeman*
Richards, Paul Douglas, *Roanoke*
Richardson, David W, *Richmond*
Richardson, Donald Wingfield, *Norfolk*
Riddick, David Haydon, *Richmond*
Rigau, Felipe Alberto, *Williamsburg*
Riker, Kerry Scott, *Richmond*
Rimple, Hubert McDonald, *Norfolk*
Ring, Susan Elizabeth, *Norfolk*
Rios, Norval A, *Tappahannock*
Ripoll, Ignacio, *Virginia Beach*
Ripple, Gary Ray, *Annandale*
Rivers, Cullen B, *Richmond*
Robbins, Andrew W, *Arlington*
Robeck, Ilene Rae, *Annandale*
Robert, Frank Chambers, *Hampton*
Roberts, Kenneth Hume, *Mechanicsville*
Roberts, William Neal, *Richmond*
Robertson, Charles H Jr, *Richmond*
Robertson, John Mott Jr, *Lynchburg*
Robertson, Ralph Herbert, *Heathsville*
Robertson, Richard Lee, *Radford*
Robey, Robert Brooks, *Arlington*
Robinson, Bryan David, *Richmond*
Robinson, Dennis H Jr, *Bedford*
Robinson, Joseph Alexander, *Richlands*
Robinson, Richard G, *Woodbridge*
Robles, Enrique Antolin, *Vienna*
Roche, James Kenneth, *Charlottesville*
Rochmis, Paul Gregor, *Fairfax*
Roda, Arturo P, *Wytheville*
Rodden, William Stephen, *Norfolk*
Rodilosso, Philip Thomas, *Arlington*
Rogan, Michael John, *Danville*
Rogers, Richard O Jr, *Franklin*
Rohleder, Kathleen Ann, *Chesapeake*
Rohrbeck, Steven Craig, *Alexandria*
Roller, Gerald W, *Roanoke*
Romano, Frank Richard, *Franklin*
Romhilt, Donald W, *Richmond*
Romney, Rebecca, *Falls Church*
Rose, Charles E Jr, *Charlottesville*
Rose, Leslie W III, *Richmond*
Rosen, Alan Aaron, *Richmond*
Rosenblatt, Arnold Jay, *Alexandria*
Rosenbloom, Alan Abraham, *Bluefield*
Rosenthal, Amy Jo, *Richmond*
Rosenthal, Norman Seth, *Burke*
Ross, George Gregory, *Fincastle*
Rossheim, Edgar H, *Norfolk*
Rothfleisch, Richard, *Virginia Beach*
Roussel, George A IV, *Harrisonburg*
Rozaki-Sismanis, Anna, *Richmond*
Rubin, Arthur A, *Arlington*
Ruckstuhl, Lily, *Falls Church*
Rudden, George T, *Arlington*
Ruddy, Shaun, *Richmond*
Rueff, Lawrence J, *Norfolk*
Ryan, Michael James, *Norfolk*
Ryan, Robert F, *Arlington*
Ryan, Robert Henry, *Springfield*
Sabella, Donald A, *Leesburg*
Sabia, Peter James, *Charlottesville*
Sachno, Roman Jr, *Staunton*
Safa, Ali Mohammad, *Vienna*
Safko, Anne Marie, *Arlington*
Sager, Dennis Wayne, *Reston*
Saladino, Lawrence P, *Vienna*
Salerno, Judith Alyce, *McLean*
Sales, Elizabeth Wellborn, *Norfolk*
Salsano, Alessio C, *Virginia Beach*
Samtani, Raj Bhagwan, *Alexandria*
Sanders, Karen Michele, *Richmond*
Santacruz, Nestor Daniel, *Norfolk*
Santangelo, Robert Paul, *Arlington*
Santos, Josefino Santos, *Chesapeake*
Sanyal, Arun Jayant, *Richmond*
Satterwhite, Cynthia Karen, *Norfolk*
Satz, Martin, *Chesapeake*
Saunders, James T, *Portsmouth*
Savage, Rodney W, *Chesapeake*
Scatarige, Carol Sachs, *Norfolk*
Schachner, Stephen Harold, *Falls Church*
Schaefer, John C, *Norfolk*
Schaffer, Charles Louis, *Richmond*
Schehl, Charles A, *McLean*
Scheld, William M, *Charlottesville*
Schewe, William J, *Virginia Beach*
Schiavoni, Edmund Stephen, *Reston*
Schlaff, Janet Marie, *Charlottesville*
Schlanger, Maurice R, *Portsmouth*
Schleupner, Charles J, *Salem*
Schmedtje, John Frederick Jr, *Richmond*
Schmeling, John William, *Annandale*
Schmitt, Brian Philip, *Richmond*
Schoolwerth, Anton C, *Richmond*
Schorling, John Bales, *Charlottesville*
Schramm, Mark Steven, *Richmond*
Schreiner, Christina Maria, *Mason Neck*
Schreiner, David A, *Arlington*
Schreiner, George E, *Great Falls*
Schroeder, Mark D, *Clifton Forge*
Schubert, Mitchell L, *Richmond*
Schuffler, Carol Susan, *Falls Church*
Schul, Jeffery Lynn, *Richmond*
Schulof, Richard Scott, *McLean*
Schumann, Harry A, *Alexandria*
Schuster, Rudolf F, *Norfolk*
Schwartz, Charles C, *Midlothian*
Schwartz, Harvey A, *Alexandria*
Schwartz, Mitchell Lonny, *Richmond*
Schwartz, Richard Alan, *Alexandria*
Schweiger, Ernst, *Portsmouth*
Schwengel, Robert Harrison, *McLean*
Scott, David William Jr, *Fredericksburg*
Scott, Robert B, *Richmond*
Scott, Samuel J Jr, *Arlington*
Scott, Stephen Carlisle, *Norton*
Scott, Thomas H, *Norfolk*
Scotti, Michael J Jr, *Arlington*
Seamon, Robert Henry, *Roanoke*
Sease, Robert H, *Harrisonburg*
Seavy, Jack F, *Virginia Beach*
Secosky, Joseph John, *Virginia Beach*
Seeherman, Robert S, *Norfolk*
Seeman, Irvin Jay, *Richmond*
Seidner, Douglas L, *Arlington*
Selvaggi, Nina, *Reston*
Sessler, Curtis Neil, *Richmond*

Internal Medicine *(cont'd)*

Sethi, Kamaljit, *Fairfax*
Setji, Prasert, *Emporia*
Shafer, William H Sr, *Winchester*
Shahane, Shirish Shyamkant, *Collinsville*
Shaikh, Farook Ahmed, *Falls Church*
Shalhoub, Robert Joseph, *Vienna*
Shamburek, Robert Dean, *Richmond*
Shapiro, Craig Scott, *Richmond*
Shaw, James Oneil Jr, *Newport News*
Sheff, Alan R, *Springfield*
Sheffer, Miles Lewallen, *Roanoke*
Shegog, James Howard, *Fort Monroe*
Shenk, Ian Marshall, *Fairfax*
Shepard, Darlinda, *Covington*
Shepheard, Stuart Lockridge, *Norfolk*
Shepherd, Eugene Bowie, *Richmond*
Sheriff, Denys Frederick, *South Boston*
Sherins, Richard Julius, *Fairfax*
Shields, Charles Patterson III, *Richmond*
Shiffman, Mitchell L, *Bon Air*
Shih, Teh-Chang, *Alexandria*
Shilling, Charles U, *Annandale*
Shim, Young S, *Hopewell*
Shogry, Mark Edward Cook, *Charlottesville*
Shor, Samuel M, *Annandale*
Shotton, Donald, *Lynchburg*
Shulmister, David, *Virginia Beach*
Shuman, Joseph Ellyn, *Falls Church*
Shurberg, Jonathan Louis, *Manassas*
Sica, Domenic A, *Richmond*
Sidhom, Magdy Kamile, *Hampton*
Sieber, Homer A, *Roanoke*
Siedlecki, Andrew Joseph, *Richmond*
Siegel, Gary R, *Virginia Beach*
Sileo, Robert Peter, *Arlington*
Silverman, Bruce Alan, *Richmond*
Simanis, Juris, *Clifton Forge*
Simon, David Bart, *McLean*
Simpao-Ignacio, Rosario D, *Springfield*
Simpkins, Garland Lee, *Virginia Beach*
Simpson, Allan G, *Falls Church*
Simpson, Thomas William, *Accomac*
Sims, Danny Michael, *Richmond*
Sinesi, Christopher Charles, *Norfolk*
Singh, Harjit, *Richmond*
Singh, Maneesha, *Annandale*
Sinusas, Albert John, *Charlottesville*
Sismanis, Anna R, *Richmond*
Sistrom, Chris Lee, *Charlottesville*
Skewes, William M, *Dublin*
Slagel, Dale Everett, *Richmond*
Slayton, Michael Edward, *Blacksburg*
Sloan, Frederick W, *Lynchburg*
Sloan, William Stringfield, *Petersburg*
Smallwood, Harvey D, *Charlottesville*
Smallwood, Katherine L, *Richmond*
Smith, Alfred L, *Richmond*
Smith, Brian Douglas, *Virginia Beach*
Smith, Charles G, *Arlington*
Smith, Jerome, *Richmond*
Smith, John Randolph, *Martinsville*
Smith, Karl Daniel, *Crozet*
Smith, Larry F, *Appomattox*
Smith, Mc Kelden, *Staunton*
Smith, Thomas Joseph, *Ashland*
Smith, William Kyle Jr, *Richmond*
Snow, Frank Richard, *Richmond*
Snustad, Diane Gail, *Charlottesville*
Snyder, Bertram C, *Arlington*
Snyder, Joseph Paul, *Suffolk*
Sobhany, Manochehr, *Woodbridge*
Soha, Walter Michael Jr, *Richmond*
Sollenberger, Michael Joe, *Charlottesville*
Soni, Chandrakanta A, *Wise*
Soobert, Karin Luule, *Chesapeake*
Soreth, Janice Marie, *Centreville*
Soriano, Alfredo P, *Chesapeake*
Soroush, Ali, *Fairfax*
South, Stephen Alan, *Roanoke*
Southerland, Hugh B, *Richmond*
Spivey, John Carl Jr, *Fredericksburg*
Splan, Thomas P, *Newport News*
Sporn, I Norman, *Richmond*
Sreekumar, Sushama N, *Alexandria*
St Andre, Arthur Charles, *Arlington*
St Clair, Jesse W III, *Virginia Beach*
Stacy, William Knox, *Midlothian*
Stahl, Jan Harris, *Charlottesville*
Stahl, Neil I, *Springfield*
Stanley, Holly Lyn, *Richmond*
Stansel, Jane Foster, *Norfolk*
Stansfield, Sally Katherine, *Woodbridge*
Staples, Ted C, *Ashland*
Stark, James J, *Norfolk*
Stark, Malcolm T, *Springfield*
Steckler, Theresa Lynne, *Crozet*
Steel, Charles W, *Suffolk*
Stefanik, Peter James, *Richmond*
Steier, Howard Charles, *Norfolk*
Stein, Emanuel, *Norfolk*
Steinberg, Adam N, *Abingdon*
Stek, Michael Jr, *Fairfax Station*
Stennies, Gail Marie, *Alexandria*
Stephens, John R, *Newport News*
Sterrett, Hatch D Jr, *McLean*
Stevenson, Fern L Davis, *Vienna*
Stewart, Forrest Marc, *Charlottesville*
Stewart, James Alan, *Chesapeake*
Stillman, Barron Herbert, *Virginia Beach*
Stith, Drury M, *Nassawadox*
Stoker, Martin Lawrence, *Arlington*
Stone, David D, *Charlottesville*
Stone, James W, *Charlottesville*
Stone, William Leete III, *Arlington*
Storm, Randle Henry, *Manassas*
Stotka, Jennifer Lynn, *Richmond*
Stott, Geraldine Ann, *Roanoke*
Stouffer, George Andrew III, *Charlottesville*
Stout, Robert E, *Hampton*
Strachan, Michael J, *Richmond*
Stringer, Kenneth R, *Richmond*
Stringfellow, James L Jr, *Bristol*
Strohhofer, Anton, *Hampton*
Strony, John Thomas, *Midlothian*
Stuckey, Charles Porter, *Richmond*
Sturgill, Thomas Wayne, *Charlottesville*
Su, Alexander, *Chesapeake*
Sullivan, James David, *Arlington*
Summers, Anne Elizabeth, *Falls Church*
Suratt, Paul M, *Charlottesville*
Suskiewicz, Lewis, *Springfield*
Sutherland, James Calvin, *Richmond*
Suttle, Grace Ellis, *Richmond*
Sutton, Valvin Earl IV, *Richmond*
Swartz, Matthew Owen, *Manassas*
Swengros, Stephen Glenn, *Newport News*
Swerdlow, Paul Steven, *Richmond*
Switz, Donald M, *Richmond*
Sydnor, Walton Kirkham, *Lynchburg*
Symes, Philip Henry, *Richmond*
Szewczyk, Celeste C, *Arlington*
Tabbara, Imadeddine Abdurrahim, *Charlottesville*
Tabor, William R, *Diggs*
Tadros, Nabil T M, *Virginia Beach*
Talreja, Roshan S, *Virginia Beach*
Tanis, Donald Jay, *Norfolk*
Tanner, William Thomas, *Alexandria*
Tansey, Claire Ann, *Charlottesville*
Tarassoff, Peter George, *Annandale*
Tatar, Steven Andrew, *Charlottesville*
Taylor, David Edmond, *Glen Allen*
Taylor, David Owen, *Richmond*
Taylor, Frank E, *Charlottesville*
Tazewell, Christine Grace, *Norfolk*
Teekah, George Anthony, *Richmond*
Telfer, Nancy, *Warrenton*
Temeles, Daniel Stewart, *Charlottesville*
Temko, Michael Hart, *Hampton*
Temme, Joel McGovern, *Alexandria*
Terlinsky, Alan S, *Arlington*
Terry, Andrew Nicholas Jr, *Chesapeake*
Terry, William S, *Portsmouth*
Thames, Marc David, *Richmond*
Thames, Thomas B II, *Norfolk*
Thiel, James Michael, *Alexandria*
Thint, Ivy, *Arlington*
Thomas, Christopher Yancey IV, *Charlottesville*
Thomas, Edward Armistead, *Roanoke*
Thomas, Geoffrey H, *Gloucester*
Thomas, Harry Roscoe Jr, *Richmond*
Thommi, George, *Roanoke*
Thompson, James Walker, *Bridgewater*
Thompson, Robert Scott, *Virginia Beach*
Thompson, William T Jr, *Richmond*
Thorn, Donald Sylvester, *Mt Holly*
Thorup, Oscar A Jr, *Charlottesville*
Thura, Peter, *Falls Church*
Thurman, Alan Lee, *Richmond*
Tiedemann, Marie T, *Richmond*
Tignor, Matthew Morgan, *Virginia Beach*
Tikoff, Gerasim, *Richmond*
Timby, Jeffrey William, *Midlothian*
Tinker, Bruce P, *Alexandria*
Tirado, Sandra, *Springfield*
Titus, Cloyd Kent, *Richmond*
Todd, Robert Michael, *Richmond*
Tolkan, Steven R, *Alexandria*
Tolver-Dingle, Peggy Venella, *Chesterfield*
Tomlinson, James Robert, *Norfolk*
Tompkins, Grover Robert, *Newport News*
Tompkins, Mary Jane, *Hampton*
Tompkins, William Fraser, *Charlottesville*
Toomy, William Nicholas, *Waynesboro*
Torbert, John V, *Lynchburg*
Touster, Michael David, *Arlington*
Tralka, George Anthony, *Vienna*
Trent, David Ford, *Richmond*
Trice, Jerry Ashby, *Fredericksburg*
Trotman, Linda Ann Mangum, *Norfolk*
Troyer, Philip Dean, *Roanoke*
Tschirgi, Laurel D, *Fairfax*

Internal Medicine *(cont'd)*

Tsou, Edward, *Vienna*
Tsun, Michael Nam Hung, *Fairfax*
Tu, Quang Ngoc, *Catawba*
Tucker, William T, *Richmond*
Tulloch, Earl F Jr, *Reston*
Tully, Christine L, *Roanoke*
Tulou, Nicolas Paul, *Richmond*
Tunney, Francis Xavier, *Virginia Beach*
Turitzin, Stephen Nicholas, *Arlington*
Turner, Franklin C, *Portsmouth*
Turner, James Witcher Jr, *Oakton*
Turner, Robert Thomas, *Arlington*
Twyman, James Baker, *Charlottesville*
Tyroler, Sidney A, *Arlington*
Ueno, Winston Mizuo, *Alexandria*
Urban, Randall James, *Charlottesville*
Urrutia-Eder, Myriam Elizabeth, *Alexandria*
Usiskin, Keith Stanley, *Richmond*
Ussher, Christopher Neville, *Roanoke*
Uzer, Matt A, *Springfield*
Uzer, Yuksel, *Springfield*
Uzsoy, Namik Kemal, *Lynchburg*
Vaid, Arun Kumar, *Chesapeake*
Valdesuso, Gladys M, *Springfield*
Valenzuela, Gregg Anthony, *Charlottesville*
Van Dyke, James Luther, *Galax*
Van Hoek, Robert, *Arlington*
Van, Truong Son, *Annandale*
Van Zee, Wayne A, *St Charles*
Vance, Mary Lee, *Charlottesville*
Vance, Vernon Keith, *Annandale*
Vanden Berg, Michael Kent, *Richmond*
Van Osten, George K, *Winchester*
Varandani, Jai K, *Pennington Gap*
Vargas, Filiberto, *Alexandria*
Vargas-Mera, Filiberto, *Alexandria*
Vaughan, David Allen, *Lynchburg*
Vaughan, David Du Puy, *Richmond*
Vaughan, Elizabeth S, *Kinsale*
Vaughn, Warren L Jr, *Richmond*
Vazquez, Suzel M, *Richmond*
Veech, Sara S, *Alexandria*
Veldhuis, Johannes Dougles, *Charlottesville*
Venkatesan, Ranganathan, *Norfolk*
Verdirame, Joseph Lorenzo, *Suffolk*
Vergara, Alfonso, *Alexandria*
Verma, Anil, *Springfield*
Vernon, Samuel D, *Marion*
Verykoukis, Athanasios, *Norfolk*
Vetro, Sam Wayne, *Arlington*
Vetrovec, George Wayne, *Richmond*
Vickers, Mark Douglas, *Richmond*
Vickery, Donald Michael, *Reston*
Vieweg, W V R, *Charlottesville*
Villafuerte, Lydora B, *Vienna*
Villarin, Alfredo Cinco Jr, *Newport News*
Villaroman, Ruben R, *Sandston*
Viol, Geoffrey William, *Richmond*
Vivadelli, Stephany Collier, *Virginia Beach*
Vorachek, Mary A, *Alexandria*
Vorona, Robert Daniel, *Virginia Beach*
Voss, John Daniel, *Arlington*
Voss, Mary Kim, *North*
Voss, Stephen Rieke, *Annandale*
Vranian, N Michael, *Richmond*
Vranian, Robert Brown, *Fredericksburg*
Wacker, Dorothea Marie, *Richmond*
Wade, Richard Terrell, *Lynchburg*
Walker, Frederic B, *Charlottesville*
Walker, Robert Wayne, *Abingdon*
Walker, William C, *Roanoke*
Wall, Mary Elizabeth, *Arlington*
Wallace, George Lamar, *Martinsville*
Wallace, Marsha T, *Alexandria*
Wallace, Pat Barrow, *Martinsville*
Walsh, Marvin Scott, *Alexandria*
Wampler, Galen Lee, *Richmond*
Wang, Moses, *Roanoke*
Ward, Bruce Horatio, *Richmond*
Ward, Franklin Ruel, *Springfield*
Ward, George W Jr, *Charlottesville*
Warner, John F, *Norfolk*
Warren, David L, *Richmond*
Warren, Robert Douglas, *Alexandria*
Warsinski, Ivy Marie, *Norfolk*
Warth, Gregory J, *Virginia Beach*
Waschler, William, *Richmond*
Wasserman, Albert J, *Richmond*
Wasserman, Brian M, *Richmond*
Watkins, Roger Alan, *Virginia Beach*
Watlington, Charles O, *Richmond*
Watson, Thelma Ruth, *Springfield*
Watts, Blake Howard, *Gum Spring*
Weaver, Albert J, *Haymarket*
Weaver, Neill K, *Arlington*
Webb, Charles Howard, *Newport News*
Webb, Christopher C, *Lynchburg*
Webb, Thomas Harry, *Portsmouth*
Weidman, Richard Clark, *Great Falls*
Weikel, Cynthia Sears, *Charlottesville*
Weisenfeld, Shirley, *Newport News*
Weissberger, Marshall Aaron, *Norfolk*
Weisz, Alice M, *Alexandria*
Welch, William James, *Richmond*
Wells, Marion F, *Wingina*
Welt, Murray Ben Zion, *Oakton*
Wenger, John Robert Jr, *Bedford*
Westbrook, Suzanne Geraldine, *Alexandria*
Westervelt, Frederic B Jr, *Charlottesville*
Westfall, Harry Lake Jr, *Fredericksburg*
Westin, Eric Henry, *Richmond*
Westmeyer, Frank C, *Norfolk*
Whateley, Brad Arthur, *Arlington*
Wheby, Munsey Stephen, *Charlottesville*
Wheeler, Robert Clews II, *Fredericksburg*
Wheless, James Elijah, *Roanoke*
White, Karen Bloxom, *Springfield*
White, Kerr L, *Stanardsville*
Whitehouse, Francis R, *Lynchburg*
Whitehurst, Mary Candace, *Norfolk*
Whitley, Thomas H Jr, *Danville*
Whitney, Jonathan P, *Roanoke*
Whittle, Joseph P, *Petersburg*
Wickham, James Robert, *Richmond*
Wigand, James P, *Midlothian*
Wiggins, Diane, *Roanoke*
Wilkenfeld, Morris J, *Vienna*
Wilkins, William Thomas, *Richmond*
Will, Michael David, *Lynchburg*
Williams, Austin T Jr, *Falls Church*
Williams, Brent Cutler, *Charlottesville*
Williams, Gerald Albert, *Keezletown*
Williams, Henry W Jr, *Arlington*
Williams, Maryanne Denise, *Charlottesville*
Williams, Michael Eugene, *Charlottesville*
Williams, Michael Talmadge, *Suffolk*
Williams, Robert O, *Richmond*
Williams, Stephen Jonathan, *Alexandria*
Willis, Hayes E, *Richmond*
Willis, Linda Griffin, *Richmond*
Wilson, Herbert Alexander III, *Newport News*
Wilson, Kevin D, *Portsmouth*
Wilson, William Allen, *Burke*
Winborne, Roger M Jr, *Roanoke*
Wine, Jean Fennell, *Harrisonburg*
Wingfield, William L, *Ashland*
Wingo, Charlie Francis, *Richmond*
Wittkamp, Bernard F Jr, *Richmond*
Wolfe, Pierre P, *Centreville*
Wong, Edward Sang, *Richmond*
Wong, Johnny C, *Richmond*
Woo, Jean So-Chun, *Richmond*
Wood, Herbert Austin, *Winchester*
Wood, Mark Allen, *Richmond*
Woodson, Charles Edward Jr, *North Garden*
Wooldridge, James Walter, *Richmond*
Wootton, Jane P, *Richmond*
Wright, Garland M, *Roanoke*
Wright, Jackson Thomas Jr, *Richmond*
Wright, James W, *Lynchburg*
Wright, John Joseph, *Falls Church*
Wright, Scott Alan, *Galax*
Wright, William Evan, *McLean*
Wu, Samuel, *Lynchburg*
Wyne, Amjad Uzair, *Pulaski*
Wynn, Alan H, *Woodbridge*
Yahanda, Hoyoko M, *Burke*
Yakshe, Paul Nolan, *McLean*
Yakub, Y Nabil, *Fairfax*
Yanovich, Saul, *Richmond*
Yarbrough, Terry Pinckney, *Portsmouth*
Yates, Harry Robert Jr, *Roanoke*
Yazel, John Joe, *Charlottesville*
Yee, Yuen San, *Richmond*
Yeh, Betty P Y, *Virginia Beach*
Yi, Chu Hon, *Virginia Beach*
Yoder, Donald E, *Pulaski*
Yoder, Gene Lee, *Linville*
Yost, Nathan Ivan, *Leesburg*
Young, Stephen Charles, *Richmond*
Young, Thomas H, *Gloucester*
Young, William Henry III, *Richmond*
Zacharias, Lawrence C, *Richmond*
Zackrison, David R, *Virginia Beach*
Zaidi, Syed Iktikharhaider, *Alexandria*
Zaidi, Syed M, *Alexandria*
Zaitoun, Keith Hamad, *Richmond*
Zaitoun, Rafic H, *Richmond*
Zaki, Omar S, *Falls Church*
Zavadil, Anthony Paul III, *McLean*
Zazakos, Christopher P Jr, *Charlottesville*
Zfass, Alvin, *Richmond*
Zfass, Hyman Samuel, *Richmond*
Zieve, Franklin J, *Midlothian*
Zilai, Janet Ann, *Richmond*
Zillhardt, Jacob Charles, *Fincastle*
Zimmet, Steven Michael, *Arlington*
Zineski, Stefan Henryk, *Fredericksburg*
Zonozi, Meer-Said, *Vienna*
Zuckerman, Bram David, *Arlington*

Internal Medicine *(cont'd)*

Zuckerman, Ellis N, *Hopewell*
Zullo, Peter John, *Gloucester*

Laryngology

Morrissett, Leslie E, *Richmond*

Legal Medicine

Bliss, Theodore III, *Norfolk*
Jordan, Jon Lyle, *McLean*
Krischer, Meyer I, *Norfolk*
Mc Menamin, Joseph P, *Richmond*
Weinacker, Robert Machel III, *Virginia Beach*
Wildner, Edwin L Jr, *Arlington*

Medical Oncology

Alberico, Thomas A, *Norfolk*
Bear, Harry D, *Richmond*
Boylan, Susan E, *Falls Church*
Byrd, Rebecca Lee, *Norfolk*
Cambareri, Richard J, *Arlington*
Cantow, Edward Francis, *Chesapeake*
Clark, William P Jr, *Virginia Beach*
Daniel, William W, *Free Union*
Dudzinski, Michelle Renee, *Virginia Beach*
Fukumoto, Donna M, *Petersburg*
Glazier, Richard Lee, *Richmond*
Goertz, Steven Richard, *Richmond*
Headley, Robert N Jr, *Lynchburg*
Heath, Robert C, *Roanoke*
Helmkamp, Boyd Frederick, *Annandale*
Higgins, Elizabeth M, *Norfolk*
Houck, William Albert Jr, *Winchester*
Inhorn, Lowell F, *Roanoke*
Kales, Arthur Norman, *Annandale*
Kemp, George M, *Norfolk*
Kersh, Charles R, *Charlottesville*
Kingery, Lou Gene, *Charlottesville*
Kuban, Deborah A, *Norfolk*
Kuperminc, Mario Jr, *Richmond*
Kustin, Jim Isaac, *Falls Church*
Kyler, Robert M, *Harrisonburg*
Lee, Sang Nam, *Falls Church*
Lewandowski, George S, *Alexandria*
May, James Terrell III, *Richmond*
Mueller, John M, *Richmond*
Oldham, Dwight S, *Lynchburg*
Roseman, James M, *Norfolk*
Rosenoff, Stephen Howard, *Roanoke*
Schertz, Gerald Lee, *Roanoke*
Sharp, Stewart A, *Danville*
Simms, Elisabeth B, *Leesburg*
Sprenkle, Wilson B, *Richmond*
Steinberg, Michael S, *Virginia Beach*
Werner, Eric James, *Norfolk*

Neonatal/Perinatal Medicine

Beck, Robert B, *Arlington*
Delfaus, Carol Gizoni, *Hampton*
Stobie, Paul Edwin, *Virginia Beach*

Neonatology

Beale, Ernest F, *Lynchburg*

Nephrology

Allison, Nancy Lynn, *Fairfax Station*
Bear, Edward Stafford, *Emporia*
Beazlie, Thomas M, *Hampton*
Choudhury, Ali Azam, *Portsmouth*
Condro, Peter Jr, *Richmond*
Dunnington, Judith S, *Richmond*
Falkinburg, Newell R, *Roanoke*
Faustino, Edgardo F, *Fredericksburg*
Gehr, Todd W B, *Richmond*
Goldberg, Marvin Jr, *Norfolk*
Goldman, Israel David, *Richmond*
Grundlehner, Marietta Ferebee, *Annandale*
Hall, Jack William, *Danville*
Harpen, Martin P, *Portsmouth*
Harris, Jeffrey P, *Winchester*
Heiman, Mitchell J, *Arlington*
Joseph, Alice Abraham, *Alexandria*
Klemmer, Philip J, *Winchester*
Lockridge, Robert S Jr, *Lynchburg*
Mathew, Mathew, *Charlottesville*
Overby, Terry Lyn, *Harrisonburg*
Pusateri, Robert J, *Newport News*
Raposo, Carlos A, *Hampton*
Roman, Jorge, *Roanoke*
Schreiber, Ronald, *Great Falls*
Smith, Stanley B, *Norfolk*
Starkman, Martin T, *Richmond*
Starling, James F Jr, *Danville*
Strauch, Barry S, *Fairfax*
Wilson, Robert Marion, *Norfolk*
Wombolt, Duane George, *Norfolk*

Neurological Surgery

Botton, Jacques E, *Lynchburg*
Clifton, Guy Lynn, *Richmond*
Cooper, Richard Coleman, *Winchester*
Eikman, Edward Allan, *Norfolk*
Foer, Warren H, *Virginia Beach*
Kendrick, John Fox, *Midlothian*
Lesnick, James Edward, *Hampton*
Mc Cullough, David C, *McLean*
Reina, Abdon, *Norfolk*
Spence, William T, *Alexandria*
Swain, Garrett M, *Locust Grove*

Neurology

Abernathy, Margaret Roberts, *Vienna*
Adams, Raymond A, *Richmond*
Alamia, Louis Joseph, *Falls Church*
Alsabbagh, Ahmad, *Richmond*
Amy, Jonathan Robert, *Alexandria*
Anderson, Charles Herbert Jr, *Salem*
Andraos, Valentina Ivanovna, *Springfield*
Astruc, Juan, *Richmond*
Barot, Amrutlal Jethalal, *Virginia Beach*
Bazaz, Lokesh K, *Arlington*
Behlmer, Patricia Maureen, *Springfield*
Bell, Zakia D, *Richmond*
Bernad, Peter G, *Alexandria*
Bivins, Don Howard, *Roanoke*
Brashear, Harry Robert III, *Charlottesville*
Brush, John J, *Richmond*
Burch, John Gordon, *Roanoke*
Calabrese, Vincent Paul, *Richmond*
Caputy, Anthony James, *Vienna*
Carmichael, Miriam W, *Richmond*
Carr, Jeri Rosenblum, *Richmond*
Chidambaram, Shobha Iyer, *Alexandria*
Cohen, Michael E, *Woodbridge*
Cohen, Robert J, *Richmond*
Colopy, Paul M, *Fredericksburg*
Cooper, Gregory William, *Charlottesville*
Curras, Maria Teresa, *Arlington*
Deandrea, Gary Anthony, *Alexandria*
De Beck, Thomas Wade, *Roanoke*
De Lorenzo, Robert J, *Richmond*
Dershewitz, Norman J, *Annandale*
Dilustro, Joseph Frank, *Norfolk*
Dorman, Jon Dudley, *Danville*
Dreifuss, Fritz Emanuel, *Charlottesville*
Fatehi, Nasrollah, *Virginia Beach*
Felton, Warren L III, *Richmond*
Freeman, Norman Robert, *Virginia Beach*
Ghaemi, Kamal, *Arlington*
Gibson, Larry, *Richmond*
Gill, Naurang Singh, *Woodbridge*
Goldhammer, Leo, *Arlington*
Gonzalez, Julio C, *Alexandria*
Grass, David B, *Fairfax*
Greenberg, Jeffrey Alan II, *Arlington*
Hall, James H, *Virginia Beach*
Hammock, Mary Kathryn, *Middleburg*
Hanna, George Russell, *Charlottesville*
Hanson, Peggy Ann, *Alexandria*
Hardy, Stephen Carl, *Richmond*
Harpold, Gary J, *Salem*
Harrelson, Austin B, *Richmond*
Harris, Jennifer Denise, *Richmond*
Harris, Joseph Kim, *Richmond*
Harris, William Overton Jr, *Newport News*
Harrison, Madaline Burr, *Charlottesville*
Haynes, Harry James, *Arlington*
Hennessey, John J IV, *Richmond*
Hoffman, Donald Lawrence, *Portsmouth*
Hormel, Timothy Louis, *Salem*
Houff, Sidney Andrew, *Arlington*
Howell, Hugh Richard, *Richmond*
Hurst, Robert Wayne, *Charlottesville*
Iglecia, Raymond, *Norfolk*
Isaacs, Edward Richard, *Richmond*
Jack, Robin Lynne, *Richmond*
Jackson, Richard T, *Radford*
Jacobs, Erwin Melvin, *Chester*
Jammes, Juan Luis, *Alexandria*
Janin, Yves, *Arlington*
Jones, David Marshall, *Richmond*
Joseph, Charles R, *Lynchburg*
Kamsheh, Mohammad Walid, *Richmond*
Karpynec, Roman, *Bristol*
Katchinoff, Barry L, *Richmond*
Kilgore, William Tommy, *Wytheville*
Klein, Kevin Mart, *Springfield*
Kopp, James Emidio, *Newport News*
Kratz, Rudiger, *Alexandria*
Kuhn, Robert Anthony, *Troutville*
Kurtzke, John Francis, *Falls Church*
Leaton, Edward M, *Richmond*
Lewis, Kathryn R, *Arlington*

Neurology *(cont'd)*

Lobar, Bruce Ian, *Staunton*
Lussky, Donald H, *Falls Church*
Madison, Catherine Ann, *Springfield*
Madonia, Eugene C, *Martinsville*
Marino, Chris Joseph, *Alexandria*
Marsteller, Blair, *Newport News*
Mc Gee, Francis E Jr, *Richmond*
Mc Crary, Morris E III, *Annandale*
Mc Pherson, Archie, *Arlington*
Mella, Barbara A, *Fairfax*
Metcalf, James Crawford, *Norfolk*
Mikszewski, Jerold, *Arlington*
Miller, James Quinter, *Charlottesville*
Moore, Margaret Susan, *Warrenton*
Moore, Michael Allan, *Danville*
Moss, Kenneth Wayne, *Arlington*
Mott, Delora Fowler, *Falls Church*
Mounaimne, Marwan Wafik, *Virginia Beach*
Nabizadeh-Eraghi, Arastoo T, *Hampton*
Nandipati, Sivarama, *Alexandria*
Nash, Robert A, *Virginia Beach*
Nolan, Donald Barry, *Roanoke*
Normand, Marlene Marie, *Richmond*
O'Bannon, John M III, *Richmond*
O'Donnell, Philip P, *Petersburg*
Otto, Mary Jean, *Farmville*
Oxenhandler, Donald C, *Alexandria*
Ozer, Mark Norman, *Richmond*
Parcells, Patrick R, *Newport News*
Pcsolyar, Dale Wilton, *Fairfax*
Pellegrino, Thomas R, *Norfolk*
Perdue, Zack Taylor III, *Harrisonburg*
Peters, Jon David, *Alexandria*
Phillips, Lawrence Hamilton II, *Charlottesville*
Rahman, Syed Habeebur, *Chesapeake*
Ranels, Richard Eugene, *Fredericksburg*
Reagan, Thomas, *Newport News*
Rennie, L E, *Richmond*
Rice, Marcus C, *Norfolk*
Rich, Elizabeth J, *Monroe*
Richards, Nelson G, *Richmond*
Riley, Harold Lee III, *Lynchburg*
Rosenbaum, Faye R, *Arlington*
Scheuer, Mark Louis, *Earlysville*
Schnoll, Sidney Howard, *Richmond*
Seipel, John H, *Fairfax*
Seith, William F Jr, *Staunton*
Sepdham, Taweesuk Jr, *Colonial Heights*
Shapiro, Samuel Leon, *Norfolk*
Sheppard, George Lester Jr, *Winchester*
Simsarian, James Parsons, *Fairfax*
Sirdofsky, Michael D, *Springfield*
Skeppstrom, Richard H, *Norfolk*
Smith, Thomas Adrian, *Richmond*
Snider, Gilbert M, *Virginia Beach*
Snyder, Roger Alan, *Fairfax*
Soll, Robert Walter, *Alexandria*
Solomon, Robert I, *Williamsburg*
Soltero, Elisa M, *Alexandria*
Sonberg, Arthur Robert, *Newport News*
Soyer, Aysegul Coskuner, *Alexandria*
St Clair, Samuel Keith, *Richmond*
Stark, Stuart Robert, *Alexandria*
Stephenson, Larry Lee, *Warrenton*
Subramaniam-Moothathu, Poovillam Subramaniam, *Petersburg*
Suter, Cary Grayson, *Richmond*
Tankoos, Amy L, *Leesburg*
Taylor, Donald A, *Richmond*
Taylor, John Richard, *Powhatan*
Trugman, Joel Michael, *Charlottesville*
Voulters, Lee, *Woodbridge*
Wallace, W Miles, *Lynchburg*
Waller, Kenneth William, *Richmond*
Waller, Richard Edmund, *Richmond*
Watkin, Terry, *Alexandria*
Waybright, Edward A, *Salem*
Wertheimer, Richard I, *Virginia Beach*
White, Gordon Osler, *Harrisonburg*
Williams, Armistead D Jr, *Norfolk*
Williams, Della C, *Danville*
Williams, Leslie B, *Alexandria*
Willis, Charles Keith, *Richmond*
Wittenborn, John Richard, *Alexandria*
Wooten, George Frederick Jr, *Charlottesville*
Worthington, Andrew K, *Richmond*
Yngente, Ellida Villa, *McLean*
Zimmerman, Richard Scott, *Richmond*
Zontine, David Herbert, *Winchester*

Nuclear Medicine

Bailey, William T, *Richmond*
Balseiro, Jesse, *Midlothian*
Bates, Hampton Robert Jr, *Richmond*
Boyle, Charles D, *Alexandria*
Burke, Patrick Kendall, *Richmond*
Chaudhuri, Tapan K, *Hampton*
Early, Warren L, *Springfield*
El-Beshbeshy, Tarek Ahmed, *Virginia Beach*
Guter, Marvin, *Richmond*
Hopkins, John David Jr, *Norfolk*
Landis, Glen Austin, *Arlington*
Litchfield, David Lee, *Richmond*
Mattay, Venkata Satyanand, *Richmond*
Nottebart, Harry Charles Jr, *Richmond*
Pinzon, Guillermo, *Danville*
Raval, Vasundhara R, *Glen Allen*
Reed, John Ernest, *Richmond*
Rose, Gary Leyton, *Vienna*
Sarshar, Mohammadali, *Annandale*
Sharpe, Alton R, *Richmond*
Teates, Charles David, *Charlottesville*
Wakat, Marshall A, *Roanoke*
Williamson, Brian Richard, *Charlottesville*
Wisoff, Carl P, *Norfolk*
Zelenak, James Joseph, *Richmond*

Nuclear Surgery

Allen, Benjamin Randolph Jr, *Richmond*
Bortnick, Ronald Jack, *Annandale*
Broaddus, William C, *Charlottesville*
Bucur, John C, *Falls Church*
Butts, Edward B, *Virginia Beach*
Carroll, Charles P H, *Arlington*
Castro, Ernesto V, *Annandale*
Clare, Frank B, *Portsmouth*
Dillon, James D, *Virginia Beach*
Dogan, M Ezel, *Annandale*
Eagles, William McCoy, *Richmond*
Erasmo, Ramon Rondobio, *Danville*
Ferry, Darwin John Jr, *Roanoke*
Garner, Wallace K, *Newport News*
Goald, Harold Jerome, *Alexandria*
Gorsen, Robert M, *McLean*
Grant, John Leland, *Portsmouth*
Griffith, Douglas Lee, *Newport News*
Gruner, George, *Richmond*
Gudeman, Steven K, *Norfolk*
Hagan, Ralph Ernest, *Richmond*
Holloway, Kathryn L, *Richmond*
Hope, Donald G, *Fairfax*
Howe, James Robert, *Alexandria*
Hurt, George Adams, *Lynchburg*
Jackson, James Robert, *Martinsville*
Jane, John Anthony, *Charlottesville*
Johnson, George William, *Richmond*
Kassell, Neal F, *Charlottesville*
Kell, Joseph F Jr, *Richmond*
Kendall, Robert Gentry, *Winchester*
Kiluk, Kenneth Ignatius, *Richmond*
Klara, Peter M, *Virginia Beach*
Lang, Edward Roberts, *Falls Church*
Loew, Albert G, *Portsmouth*
Magness, Alfred P II, *Norfolk*
Marsh, Kim E, *Richmond*
Mc Adam, Richard Bernard, *Hampton*
Mc Allister, John Eldon, *Winchester*
Mc Cutcheon, Ian Earle, *Reston*
Mc Fadden, Joseph T, *Norfolk*
Neal, Richard King, *Norfolk*
Peach, William Fennell, *Newport News*
Penix, Jerry O'Don, *Norfolk*
Preuss, James William, *Alexandria*
Rashti, Robert A, *Norfolk*
Richmond, Isabelle L, *Norfolk*
Rinaldi, Italo Pio, *Newport News*
Rish, Berkley Lamont, *Kempsville*
Rosemblat, Aldo M, *Falls Church*
Rouady, William A, *Woodbridge*
Sahni, K Singh, *Richmond*
Salame, Camille George, *Richlands*
Schinco, Frank P, *Norfolk*
Shevlin, William Anthony, *Gainesville*
Singer, Robert Perry, *Richmond*
Smith, Mathew Norris, *Fairfax*
Stevens, Ward William Jr, *Roanoke*
Swan, Robert John, *Portsmouth*
Sweet, Raymond C, *Petersburg*
Tice, William Preston, *Roanoke*
Toczek, Stanislaw K, *Alexandria*
Ulmer, Jack L, *Richmond*
Varner, John D, *Roanoke*
Vascik, James M, *Roanoke*
Velo, Anthony Gomez, *Richmond*
Ward, John D, *Richmond*
Waters, David Carl, *Norfolk*
Weaver, Edgar N Jr, *Roanoke*
Weaver, Edgar Newman, *Roanoke*
White, William Richard, *Richmond*
Wilson, Claude Watson, *Richmond*
Wright, R Lewis, *Richmond*
Young, Harold Francis, *Richmond*

Nutrition

Kasdin, Jack, *Highland Springs*

Obstetrics

Majewski, Allen David, *Lynchburg*

Obstetrics/Gynecology

Adkins, William E, *Suffolk*
Adler, Alf K, *Woodbridge*
Agee, Robert Lee IV, *Farmville*
Ahdoot, Habibollah, *Alexandria*
Akbar, Farooq, *Leesburg*
Alston, Rebecca Baker, *Suffolk*
Amor, Ramon Lino, *Newport News*
Amorosi, Leo David, *McLean*
Andersen, Glenna R, *Annandale*
Anderson, Abraham S, *Norfolk*
Anderson, Duane C, *Vienna*
Anderson, James Edward, *Vienna*
Anderson, Mervan O, *Norfolk*
Andrews, Mason C, *Norfolk*
Ante, Nilda R, *Richmond*
Archer, David, *Norfolk*
Archer, Thomas Patrick, *Chesapeake*
Archer, William Reynolds III, *Fairfax*
Argyle, Heather Ann, *Newport News*
Aria, James Jamal, *Alexandria*
Armstrong, Nancy Jamison, *Richmond*
Armstrong, Norman Alva, *Falls Church*
Asmar, Pierre, *Annandale*
Awad, Allen J, *Richmond*
Axelrod, David Zuckerman, *Alexandria*
Azoury, Ramez S, *Norfolk*
Bacaj, Taullah, *Alexandria*
Bader, Joanne, *Norfolk*
Baggs, W James, *Newport News*
Bagley, John J, *Richmond*
Baker, Jay Milton, *Virginia Beach*
Baker, John Harrison, *Williamsburg*
Baker, Richard Holden, *Blacksburg*
Baker, William Frank, *Lynchburg*
Bangel, William M, *Hampton*
Barnes, Everett D, *Alexandria*
Barnes, Willard Aaron Jr, *Alexandria*
Barnett, Jewell Milton, *Newport News*
Barrett, Debra Ann, *Highland Springs*
Bateman, Bruce G, *Charlottesville*
Battista, Joseph Victor Jr, *Richmond*
Bauer, Paul Richard, *Chesapeake*
Beaver, Harry Carl, *Annandale*
Beckerman, Tobie Ely, *Arlington*
Beier, Karl Martin, *Franklin*
Belinsky, Samuel Michael, *Vienna*
Bell, Donald B, *Virginia Beach*
Bell, Thomas G, *Staunton*
Bentrem, George C, *Manassas*
Berenguer, Thomas J, *Virginia Beach*
Bernardo-Solis, Myrna Atacador, *Virginia Beach*
Bettini, Robert John, *Burke*
Billett, Todd Evans, *Richmond*
Bing, Herbert E, *Staunton*
Birdsong, Gordon G, *Franklin*
Blanton, Erika M, *Richmond*
Blass, Norman Herbert, *Richmond*
Blattner, Carlos J, *Galax*
Board, John Arnold, *Richmond*
Bolash, Alan Michael, *Williamsburg*
Bolen, John William, *Galax*
Bolvari, Joseph J, *Manassas*
Booker, Sylvester C, *Alexandria*
Boone, Lewis Benton, *Richmond*
Booth, Hobson G, *Harrisonburg*
Borzelleca, Joseph F Jr, *Richmond*
Bowden, Robert Henry Jr, *Lynchburg*
Bower, Richard Edward, *Richlands*
Brady, Douglas, *Woodbridge*
Branch, David W, *Roanoke*
Brawner, Sandra Lee, *Midlothian*
Breit, Bruce H, *Richmond*
Brennan, Robert J, *Springfield*
Briguglio, Philip P, *Alexandria*
Broach, William E III, *Danville*
Brock, Ellen Louise, *Richmond*
Broocker, Warren Alan, *Richmond*
Brosch, Gad E, *Virginia Beach*
Brown, Cyrus U, *Hampton*
Bruno, Alphonse H L Jr, *Norfolk*
Bryan, Pat Chappell, *Charlottesville*
Bryant, Shawne R, *Virginia Beach*
Bryce, Peter Alexander, *Alexandria*
Brzyski, Robert Gerard, *Norfolk*
Buchanan, Camilla M, *Williamsburg*
Bukszar, Kathleen Cauble, *Woodbridge*
Bullock, Henry A Jr, *Richmond*
Bump, Richard C, *Richmond*
Burka, Paul Stephen, *Falls Church*
Burke, Patrick Declan, *Culpeper*
Burnett, Alexander M, *Arlington*
Burton, Ted Fuqua, *Radford*
Bustillo, Maria Del Carmen, *Fairfax*
Caine, Thomas P Jr, *Newport News*
Calloway, William C, *Richmond*
Campbell, Mary I, *Annandale*
Camper, Harry G III, *Harrisonburg*
Cane, James Howard, *Richmond*
Canizares, Teresita Cacha, *Fredericksburg*
Carbone, Ralph, *Arlington*
Carlson, David Roland, *Fairfax*
Cartagena, Rodolfo S, *Norton*
Castle, Robert L, *Burke*
Cates, Michael A, *Charlottesville*
Chamberlain, Richard R, *Moneta*
Chambers, Zerline Evelyn, *Springfield*
Chanachote, Udom Jr, *Front Royal*
Chesson, Ralph R Jr, *Norfolk*
Childress, Alva J Jr, *Virginia Beach*
Choudhry, Arshed A, *Sterling*
Chung, Sung Ai Lee, *Portsmouth*
Ciofalo, Carol Ellen, *Arlington*
Claiborne, Herbert A Jr, *Richmond*
Clapp, Debra Hart, *Roanoke*
Claytor, John B Jr, *Roanoke*
Clingenpeel, J Floyd, *Franklin*
Close, James McClay, *Annandale*
Cohen, Stephen A, *Richmond*
Cole, Ralph John, *Falls Church*
Coleman, Richard L M, *Staunton*
Collins, Beth A, *Roanoke*
Cook, William A Jr, *Lynchburg*
Cooksey, William Perry, *Richmond*
Cooley, Stewart Dallas, *Fairfax*
Cornell, George Willett, *Suffolk*
Corney, Margie, *Portsmouth*
Cox, William Henry, *Richmond*
Crane, John E, *Emporia*
Crockford, Jon Lee, *Norfolk*
Crooks, Lewis Daniel Jr, *Midlothian*
Cross, John Earle, *Winchester*
Crowe, Walter G, *Springfield*
Cuesta, Maximo Lopez, *Roanoke*
Cunningham, Dean Scott, *Virginia Beach*
Curtis, Walter Jr, *Hampton*
Cutting, Mary E, *Alexandria*
Dabinett, Laura Nevins, *Charlottesville*
Dahm, Norman Richard, *Virginia Beach*
Dang, Thao Phuong, *Falls Church*
Darracott, Mixon Milford, *Staunton*
Datoc, Roberto L, *Alexandria*
Davidson, Kim Marie, *Richmond*
Davis, Algernon Gibson, *Roanoke*
Davis, Charles Y, *Blacksburg*
Davis, Mary M, *Falls Church*
Davis, William Vaughan, *Roanoke*
Davoudlarian, David K, *Arlington*
De Alessandrini, Luigi, *Virginia Beach*
Dean, Howard Yates, *Radford*
Deep, Anthony Abraham, *Richmond*
Defreitas, Eric Allan, *Chesapeake*
Delorme, Donald P, *Alexandria*
Denaro, Frank Jr, *Chesapeake*
Denis, Andre Lucio Cardoso, *Norfolk*
De Sandies, Kenneth A, *Fairfax Station*
Dessouky, Dessouky A, *McLean*
Devine, Joan W, *Virginia Beach*
De Vocht, Ludovic Jules, *Alexandria*
Di Bona, Douglas D, *Virginia Beach*
Dineen, Mary Kay, *Williamsburg*
Dispenza, Sebastian J Jr, *McLean*
Donald, Felicia Lyn, *Fairfax*
Donald, Howard A, *Falls Church*
Doppelheuer, John David, *Annandale*
Driskill, William L Jr, *Lynchburg*
Droesch, James Norbert, *Virginia Beach*
Droesch, Kathleen Elizabeth, *Virginia Beach*
Dunkwu, Anthony Amechi, *Alexandria*
Dunn, Leo James, *Richmond*
Durcan, Frank J, *Fredericksburg*
Dwork-Berger, Amy G, *Vienna*
Eads, Robert Stephen, *Richmond*
Earnhardt, Herman L Jr, *Fredericksburg*
Edelstein, Michael Charles, *Virginia Beach*
Edwards, Norman Ross, *Newport News*
Eliacin, Louis Edgard, *Blairs*
Ellen, Joseph Harry, *Richmond*
Ellett, Rufus P Jr, *Moneta*
Elliott, John J, *Arlington*
Ellis, William Dewitt, *Danville*
Elstein, Morris M, *Virginia Beach*
Elswick, Ronald Kenneth, *Radford*
Emery, Janice J, *Fairfax*
Eppard, Leonard C, *Annandale*
Espinola, Mario E, *Fairfax*
Evans, Frederick Carlyle, *South Boston*
Falo, Pablo Antonio, *Arlington*
Fanale, Joachim M, *Woodbridge*
Fantl, Juan A, *Richmond*
Farber, Steven Lee, *Roanoke*
Fears, Richard B, *Nassawadox*
Feore, John Colman, *Richmond*
Ferguson, James Edward II, *Charlottesville*
Fernandez, Frank L, *Williamsburg*
Ferrell, Haskins Jr, *Alexandria*
Fiedler, Adam J, *Richmond*

Obstetrics/Gynecology *(cont'd)*

Fields, Joseph Edward, *Williamsburg*
Fieo, Richard L, *Winchester*
Fierro, Robert J, *Richmond*
Filak, Stefani J, *Annandale*
Filipescu, Nicolae, *Arlington*
Fine, Edward K, *Martinsville*
Fitzhugh, William Garth, *Richmond*
Flaherty, Thomas F, *Rixeyville*
Fleet, Clifford B Jr, *Richmond*
Flood, Jill Taylor, *Virginia Beach*
Fonteyn, Viviane J, *Springfield*
Forbes, Sarah Elizabeth, *Newport News*
Foreman, William Sidney, *Forest*
Forrest, David C, *Richmond*
Forth, Richard V, *Roanoke*
Fox, C H, *Charlottesville*
Franasiak, Frank E, *Chesapeake*
Freeman, George Hartley, *Richmond*
Freier, Andrew Ammud, *Fairfax*
Fruiterman, Jan Paul, *Burke*
Fryar, Mel Webster, *Radford*
Gaddy, Norma Ellen, *Norfolk*
Gahres, Edward E, *Alexandria*
Gaither, Dorothy Beverly, *Alexandria*
Galdos, Manuel, *Hampton*
Garcia, Alberto J, *Vienna*
Garcia, Jorge M, *Roanoke*
Garcia, William John, *Reston*
Garreau, Elizabeth Ann, *Alexandria*
Garst, Arthur H Jr, *Roanoke*
Garvez, Magdalena D, *Woodbridge*
Gayle, John F, *Hampton*
Gentile, Francis G, *Midlothian*
Gerber, Charles Trenton, *McLean*
Ghramm, John William, *Winchester*
Giammittorio, David C, *Alexandria*
Gibson, Janice Lynn, *Richmond*
Gilkey, John M, *Lynchburg*
Gillanders, Robert James, *Vienna*
Given, Fred T Jr, *Norfolk*
Glover, Roger A Jr, *Abingdon*
Godfrey, Peter Edward, *Culpeper*
Gonzalez, John, *Manassas*
Gooch, Garrett G III, *Salem*
Goodner, John Wood, *Richmond*
Goplerud, Dean Roy, *Richmond*
Gospodnetic, Marijan, *Richmond*
Graham, Charles McDonald, *Radford*
Grapin, Fern Lorraine, *Alexandria*
Gravatt, Arthur B, *Kilmarnock*
Gray, Derwin Pearson, *Hampton*
Gregg, Karl Vardell, *Newport News*
Gregor, Henry F, *Martinsville*
Gresinger, Thomas Hamlin, *Fairfax*
Griffin, Francis G, *Virginia Beach*
Grimm, Samuel Oliver III, *Fairfax*
Grizzard, William Samuel, *Petersburg*
Grizzard, William Samuel Jr, *Petersburg*
Gross, Barry Lee, *Newport News*
Grossman, Peter Daniel, *Richlands*
Groves, C Dwight, *Virginia Beach*
Gueriera, Charles Joseph, *Manassas*
Gustafson, Mark Worsham, *Roanoke*
Haas, Theron Henry, *Radford*
Habel, James M Jr, *Suffolk*
Haddad, Joseph B, *Richmond*
Hair, Joyce P, *Fairfax*
Hall, Debra Lynn, *Annandale*
Hall, Robert B, *Winchester*
Halsey, J Kaye, *Charlottesville*
Hamilton, James F, *Kilmarnock*
Hamilton, Stuart H Jr, *Richmond*
Hammer, Jeff Charles, *Chesapeake*
Han, Choong Suk, *Annandale*
Han, Joan Plotkin, *Richmond*
Hancock, John Dennis, *Roanoke*
Hancock, Philip Hurt, *Newport News*
Handy, Russell Lee, *Richmond*
Hanna, Thomas L, *Newport News*
Hanson, Lisbet M, *Virginia Beach*
Harbert, Guy Morley Jr, *Charlottesville*
Hardee, Gregory Deleslie, *Roanoke*
Harlfinger, Erwin Herbert, *Richmond*
Harms, Carl Barnard, *Salem*
Harralson, John David, *Lexington*
Harter, Basil T, *Bristol*
Hasan, Nasira F, *Pennington Gap*
Hatcher, Ronald Allen, *Woodbridge*
Hatten, John Q, *Newport News*
Hays, Patricia Mary, *Richmond*
Heider, Robert Roy, *Charlottesville*
Heist, Cynthia S, *South Hill*
Henneman, Linda Kyle Horan, *Norfolk*
Heritage, Douglas E, *Woodbridge*
Hernandez, Antonio, *Alexandria*
Herrick, Beth Bernadette, *Arlington*
Herrman, Joanne, *Fairfax*
Hersh, Camilla Carroll, *Fairfax*
Heyl, Peter S, *Annandale*
Hill, Robert Middleton, *Newport News*
Himmelstein, Lisa Ruth, *Alexandria*
Hindman, Hal Barton, *Woodbridge*
Hirsch, Jack Samuel, *Charlottesville*
Ho, Thuy Nguyen, *Petersburg*
Hogge, William Allen, *Charlottesville*
Holman, James Freeman, *Salem*
Holyfield, Paul Alfred, *Martinsville*
Hooper, E Marie, *Farmville*
Hopwood, Herbert G, *Arlington*
Howard, Robert Edwin Jr, *Hampton*
Hoyne, Patricia Mary, *Arlington*
Hudson, Gwendolyn S, *Richmond*
Hughes, G Theodore, *Norfolk*
Humsi, Ramzi Kamel, *Marion*
Hundley, Jean Catherine, *Alexandria*
Hunsaker, R Dale, *Portsmouth*
Hunt, Charles F, *Charlottesville*
Hurlock, Donna G, *Alexandria*
Hurt, Alvin Judson, *Roanoke*
Hurt, W Glenn, *Richmond*
Hyung, Joon Kil, *Fredericksburg*
Inloes, Benjamin H Jr, *Williamsburg*
Irons, Raymond Jack, *Lynchburg*
Irvin, Robert Wheary Jr, *Roanoke*
Isaac, Joseph William, *Virginia Beach*
Isenhour, William Apperson, *Blacksburg*
Ivy, Michael Warren A, *Falls Church*
Jackson, Robert Bruce II, *Abingdon*
Jarrett, Harry Walthall, *Lynchburg*
Javaid, Perwaiz A, *Chesapeake*
Jayanetti, Sidath, *Chesapeake*
Jeffrey-Coker, Lami, *Arlington*
Jenkins, Daniel George, *Williamsburg*
Jennings, C Leon Jr, *Roanoke*
Jensen, Jeffrey Thomas, *Chesapeake*
Johns, Montgomery N, *Fredericksburg*
Johnson, Bruce E, *Richmond*
Johnson, Kenneth Roger, *Alexandria*
Johnson, Lester Dean Jr, *Falls Church*
Jones, George Robert, *Richmond*
Jones, Herbert C Jr, *Charlottesville*
Jones, James Edward Jr, *Richmond*
Jones, Michael Clayton, *Roanoke*
Jones, Roger William, *Williamsburg*
Jones, William Collins, *Richmond*
Jusay, Felciano J, *Wytheville*
Juskevich, Robert S, *Virginia Beach*
Kalesh, Douglas George, *Arlington*
Karande, Vishvanath Chandrakant, *Virginia Beach*
Karmy, Robert John, *Woodstock*
Kaveski, Mary Ann J, *Richmond*
Kazakis, T Ross, *Virginia Beach*
Kazakis, Traintafllos D, *Virginia Beach*
Keblusek, Charles W, *Richmond*
Keffer, Louis H, *Newport News*
Kelly, James A, *Salem*
Kennedy, Kris Elaine, *Falls Church*
Khachikian, Grigor, *Alexandria*
Khoury, Alfred N, *Annandale*
Kil, Hyung Joon, *Fredericksburg*
Kilmer, Jennifer Lynn, *Alexandria*
Kim, Chungkook, *Fairfax*
Kim, Mi Yong, *Fairfax*
Kirby, David Alan, *Fredericksburg*
Kitchin, James David III, *Charlottesville*
Klink, Robert W, *Gloucester*
Knapp, Karen Elizabeth, *Midlothian*
Knight, Aubrey Lee, *Roanoke*
Knight, Frank Sutton, *Richmond*
Knispel, John William, *Virginia Beach*
Koch, Edward G, *Arlington*
Kojac, George H, *Fairfax*
Kolp, Lisa Ann, *Ivy*
Kolvereid, Edward Ronald, *Annandale*
Kramer, Ralph Lewis, *Alexandria*
Krebs, Hans Bartold, *Annandale*
Kudaravalli, Krishnarao Venkata, *Petersburg*
Kuhlmann, Randall Scott, *Norfolk*
Kutzner, Deann Chrispens, *Barboursville*
Lacayo, Edgard, *Alexandria*
Lackore, Raymond Clayton III, *Virginia Beach*
Lang, Joanne, *Waynesboro*
Larsen, George Douglas, *Lexington*
Larue, Patricia Ann, *Burke*
Laserna, Oscar Magno, *Fredericksburg*
Laserna, Rosario G, *Fredericksburg*
Lassere, Michael W, *Clifton Forge*
Laufer, Gabor Geysa, *Alexandria*
Lautman, Lee Paul, *Virginia Beach*
Leary, Patrick J, *Vienna*
Lee, Chun Sheng, *McLean*
Lee, John Edward, *Chesapeake*
Le Hew, Willette Lewis, *Norfolk*
Leon, Stephen Howard, *Fairfax*
Lepore, Michael A Jr, *Portsmouth*
Leslie, Kimberly Kay, *Alexandria*
Levine, Leonard S, *Springfield*
Levy, Donald Lazare, *Norfolk*
Limaye, Nirmala S, *Arlington*
Lin, Jeng Yih, *Wheeling*

Obstetrics/Gynecology *(cont'd)*

Lippard, Carroll H, *Lynchburg*
Lloyd, Samuel J Jr, *Warrenton*
Lloyd, Thomas Stacy Jr, *Fredericksburg*
Lockhart, John Lee, *Newport News*
Loderstedt, Gunther J, *Pulaski*
Loewith, Margaret H, *Arlington*
Lotfi, Ali, *Herndon*
Lowder, John H Jr, *Winchester*
Lowe, Scott Miller, *Norfolk*
Lucas, Susan J, *Reston*
Lyles, John William Jr, *Annandale*
Mac Donald, Linda Drake, *Arlington*
Maciulla, Lori Jean, *Falls Church*
Maciulla, Louis J, *Arlington*
Maciulla, Louis Joseph, *Arlington*
Mac Ivor, Duncan Campbell, *Richmond*
Mack, Theodore R, *Richmond*
Maclean, Marion Elizabeth, *Fort Myer*
Maddox, John Frank, *Fairfax*
Maddox, Joseph Edward, *Winchester*
Mahnesmith, Randolph C, *Waynesboro*
Maizels, Max S, *Richmond*
Majdi, Ali Mokhtari, *Falls Church*
Maltese, Frances Anna, *Richmond*
Maraist, Adrienne Louise, *Richmond*
Margulies, David M, *Fairfax*
Marquardt, Eveline Beatrice Muller, *Reston*
Marsella, John Jerry, *Danville*
Marshall, Charles B, *Martinsville*
Marshall, John Talmadge, *Petersburg*
Martel, Leon Alphonse Jr, *Falls Church*
Martin, Dean H, *McLean*
Martin, George W, *Falls Church*
Martin, Maurice H, *Kilmarnock*
Martin, William Leroy, *Virginia Beach*
Martinez, Marina I, *Arlington*
Mason, Cheryl Annette, *Danville*
Match, Joel Wayne, *Fairfax Station*
Matthews, Carolyn Michelle, *Richmond*
Matzkin, Richard Charles, *Pounding Mill*
Maute, Frederick C, *Danville*
Maxymiv, George W, *Roanoke*
May, Russell L, *Annandale*
Maya, Hector J, *Great Falls*
Mc Bride, Robert P III, *Richmond*
Mc Cants, Odell, *Arlington*
Mc Cauley, Janet Lynn, *Norfolk*
Mc Cue, Raymond L, *Manassas*
Mc Entee, James Phillip, *Richmond*
Mc Falls, James C, *Arlington*
Mc Gavin, Thomas A, *Arlington*
Mc Laren, Rodney Anthony, *Arlington*
Mc Lennan, Lee A, *Roanoke*
Mc Leod, Harry Ronald, *Leesburg*
Mc Millan, Daniel Burnes, *Staunton*
Mc Whorter, W David, *Winchester*
Mecklenburg, Fred Emil, *Great Falls*
Meeks, Rita Ann, *Virginia Beach*
Mehta, Shobha N, *Alexandria*
Meincke, David Lee, *Blacksburg*
Melnick, Gary Neil, *Burke*
Meyer, Julien H, *Roanoke*
Meyer, Julien H Jr, *Roanoke*
Miller, Donald Harner, *Norfolk*
Miller, Newton Byrd, *Norfolk*
Minor, Philip Lee Allen, *Richmond*
Mistry, Farookh D, *Portsmouth*
Mobley, Cynthia H, *Norfolk*
Montague, David Lee, *Richmond*
Montgomery, Howard Arthur, *Charlottesville*
Moore, Charles Coleman Jr, *Richmond*
Moore, Frederic P III, *Richmond*
Moore, James Daniel Jr, *Abingdon*
Moorman, John Hope Jr, *Martinsville*
Morgan, Franklin G Jr, *Norfolk*
Morrison, J Donald, *Newport News*
Moseley, Charles Hilary, *Petersburg*
Moxley, Thomas Wayne, *Richmond*
Moy, Russell W, *Culpeper*
Muasher, Suheil Jamil, *Norfolk*
Muhlendorf, Ivan K, *Norfolk*
Mulhollen, Annalisa, *Vienna*
Munabi, Abraham Kwadu, *Fairfax*
Murthy, Yelameli S, *Cedar Bluff*
Mussenden, Caryl G, *Falls Church*
Myers, Thomas Edward, *Warrenton*
Nance, Larry Allen, *Manassas*
Napier, Dennis Lee, *Newport News*
Nasr, Munir F, *Norfolk*
Neiman, Wade A, *Lynchburg*
Nelson, Lawrence Merle, *Herndon*
Newman, Cyril, *Chesapeake*
Nickerson, Charles William, *Newport News*
Niles, Richard Allen, *Lynchburg*
Nipe, George Maynard, *Harrisonburg*
Nirmul, Josodera, *Suffolk*
Nolan, Mark Warren, *Newport News*
Noonan, Daniel J, *Charlottesville*
North, Arthur W, *Wise*
Nottingham, Carol W, *Norfolk*
Nowroozi, Pouran Nadji, *Norfolk*
Nunley, Wallace C Jr, *Charlottesville*
O'Connell, Timothy Andrew, *Newport News*
Oehninger, Sergio C, *Norfolk*
Okkema, Julia Mae, *Alexandria*
Olinger, David Phlegar, *Richlands*
Oppenhimer, William M, *Richmond*
Oredein, Olugbenga S, *Norfolk*
O'Regan, Maureen, *Arlington*
Ozberkmen, Yacit Yakup, *Annandale*
Palmeri, Russell F, *South Hill*
Paredes, Victor M, *Richmond*
Park, Philip Marlin, *Chesapeake*
Partridge, John Robert, *Richmond*
Pasley, William W, *Roanoke*
Patterson, John Richard, *Danville*
Paulson, John D, *Alexandria*
Payette, John Joy, *Culpeper*
Payman, Bahman, *Marion*
Payne, Francis Robert Jr, *Petersburg*
Pearce, David Christopher, *Richmond*
Perkins, Paul Hening, *Waynesboro*
Perloe, Mark, *Springfield*
Perwaiz, Javaid A, *Chesapeake*
Peterson, Christine Marie, *Charlottesville*
Petres, Robert Evan, *Richmond*
Pharr, Percy Paul Jr, *Newport News*
Picot, Harrison, *Alexandria*
Piness, Jane E, *Falls Church*
Pinkerton, Jo Ann Vensko, *Charlottesville*
Policelli, Vincent A, *Vienna*
Pontier, Paul Jeffrey, *Chesapeake*
Porter, Norman A Jr, *Lynchburg*
Potkul, Ronald Keith, *Arlington*
Presnell, Timothy Andrew, *Richlands*
Price, Kazuko Kukita, *Alexandria*
Price, Neel J, *Falls Church*
Psimas, James N, *Portsmouth*
Pugsley, Louis Quain, *Fairfax*
Punyanitya, Voranoot J, *Charlottesville*
Puray, Teofilo Aparis, *Front Royal*
Puritz, Holly Suzanne, *Norfolk*
Putze, Robert Leroy, *Franklin*
Pyle, Pamela G, *Virginia Beach*
Rabhan, Nathan H, *Richmond*
Radice, Luis C, *Alexandria*
Raitz, Lee Allen, *Springfield*
Rajaee, Shahabeddin, *Alexandria*
Ramsey, Ali K, *Woodbridge*
Rand, William K III, *Norfolk*
Randall, Glenn H, *Virginia Beach*
Randolph, Bruce L, *Richmond*
Rao, Edward Krishna, *Arlington*
Rarick, Lisa Rosburg, *Arlington*
Rattner, Susan L, *Fairfax*
Rector, George Jr, *Chesapeake*
Reddy, P Vijay, *Petersburg*
Reddy, Pannala V, *Petersburg*
Redwine, Fay O, *Richmond*
Regan, Robert M, *Manassas*
Reilly, Michael John, *Harrisonburg*
Reingold, William N, *Norfolk*
Reiter, Mark B, *Arlington*
Rend, Charles Ambrose, *Williamsburg*
Reskallah, Totmes Tewfik, *Colonial Heights*
Reutinger, David Charles, *Richmond*
Rhoads, John Charles, *Manassas*
Rhymers, Kurt Lee, *Alexandria*
Ridgway-Hull, Duvahl B, *Roanoke*
Riley, Chester Loris, *Winchester*
Rinehardt, Richard Frederick, *Richmond*
Robbins, Clement Jay III, *Fredericksburg*
Roberson, William, *McLean*
Roberts, Alfred M, *Virginia Beach*
Roberts, Herbert Ray, *Lorton*
Roberts, Lucien Wood Jr, *South Boston*
Roblete, Beulah V, *Covington*
Rogers, William Hamilton, *Suffolk*
Roman, Janice, *Virginia Beach*
Rosanelli, Peter Jr, *Richmond*
Rosen, Leonard A, *Burke*
Rosenbaum, Meyer Jr, *Arlington*
Rosenberg, Sanford M, *Richmond*
Ross, Michael A, *McLean*
Ross, Stephen Jon, *Roanoke*
Rossi, Gustavo A, *Arlington*
Rothman, Barry S, *Alexandria*
Rothschild, Peter G, *Fairfax Station*
Royal, Harry Willis, *Richmond*
Royster, Clarence Edward, *Fredericksburg*
Ruhnke, Edward E Jr, *Petersburg*
Ryan, John Edward, *Arlington*
Sabella, Lareine, *McLean*
Salyer, Thomas D, *Suffolk*
Sanders, John, *Falls Church*
Santiago, Gloria A, *Virginia Beach*
Sanz, Luis E, *McLean*
Sarrett, David Lee, *Virginia Beach*
Sarrett, Kemper Davis, *Hampton*
Saul, Patton B, *Roanoke*

Obstetrics/Gynecology *(cont'd)*

Saul, Slater Cumbermac, *Norfolk*
Saunders, John R Jr, *Lynchburg*
Sayegh, Susie Kelly, *Norfolk*
Scharlop, Beth, *Virginia Beach*
Schick, Eduardo Jorge, *Virginia Beach*
Schiller, Maurice, *Springfield*
Schmitt, Thomas Edward, *McLean*
Schoeffler, Edmund Dwight, *Richmond*
Schulman, Jeffrey M, *McLean*
Schultz, Robert Gwynn, *Harrisonburg*
Scott, David Randolph, *Nassawadox*
Scott, Karen Riddell, *Arlington*
Scott, Richard Thomas, *Virginia Beach*
Scott, Thomas Walter, *Falls Church*
Sedwick, Richard E N, *Harrisonburg*
Seitz, Georg Karl, *Manassas*
Selden, John Samuel Jr, *Norfolk*
Sethi, Hercharan K, *Mc Lean*
Shaffer, David N, *Alexandria*
Shapiro, Jerome Joseph, *Goldvein*
Shaughnessy, Katherine T, *Richmond*
Shieh, Frank F, *Petersburg*
Sholk, Alvin, *Newport News*
Shuman, Lawrence Henry, *Falls Church*
Shwayder, James M, *Newport News*
Shwayder, Robert Craig, *Newport News*
Sigleo, Susan H, *Annandale*
Simmons, Robert George, *Danville*
Simon, James Alan, *McLean*
Siriwatharangoon, C, *Hopewell*
Sites, James G, *Falls Church*
Smeltzer, James Stewart, *Richmond*
Smith, Claude A, *Norfolk*
Smith, Gary W, *Virginia Beach*
Smith, Paul S, *Richmond*
Snir, Arye N, *Tysons Corner*
Solano, Simon, *Arlington*
Solomon, Susan M, *Richmond*
Soper, David E, *Richmond*
Spruiell, Michael, *Norfolk*
Stafford, James H Jr, *Winchester*
Stanley, Covia Levance, *Richmond*
Stanley, James B, *Virginia Beach*
Steeley, Gwen Scott, *Leesburg*
Stein, Jerome Jr, *Alexandria*
Steingold, Kenneth Alan, *Richmond*
Stephens, Bertram E S, *Hampton*
Stephenson, Laura Lee, *Lexington*
Stern, Eric, *Springfield*
Stewart, Kathryn P, *Lynchburg*
Stiff, Leroy E, *Hampton*
Stockstill, Leigh H, *Roanoke*
Stoeckel, Catherine R, *Waynesboro*
Stohrer, Anne E, *Falls Church*
Stoker, Donald R, *Fredericksburg*
Stokes, Richard L, *Reston*
Strawbridge, Wendy Replogle, *Abingdon*
Stroud, David Walker, *Roanoke*
Sun, Beryl K G, *Chesapeake*
Supetran, Virgilio Conlu, *Hopewell*
Swallow, Elizabeth, *Harrisonburg*
Syme, Robert H, *Alexandria*
Tabrizi, Mehdi Fakher, *Alexandria*
Tacktill, Norman, *Alexandria*
Talbert, John Robert, *Waynesboro*
Tart, Nelson Monroe, *Falls Church*
Tashman, Hunter Scott, *Fairfax*
Tasker, John James, *Pulaski*
Tayal, Sudesh Bala, *Radford*
Taylor, Peyton T Jr, *Ivy*
Tchabo, Jean-Gilles, *Arlington*
Tensen, Nilda Jo, *Richmond*
Thanaporn, Prasit, *South Boston*
Thedieck, Charles G, *Richmond*
Thiagarajah, Siva, *Charlottesville*
Thiel, Melissa Joy, *Alexandria*
Thom, Douglas, *Newport News*
Thomas, Harry Jr, *Richmond*
Thompson, Harry Glenn, *Alexandria*
Thompson, Robert Bell, *Staunton*
Thornton, William N Jr, *Charlottesville*
Thurston, Candace Sharon, *Falls Church*
Tissera, Jose Saul, *Fairfax*
Titus, Frederick Preston, *Alexandria*
Tomeu, Enrique J, *Virginia Beach*
Tomlin, Henry Lewis, *Petersburg*
Tomlinson, H Evangeline, *Alexandria*
Tomzak, Thomas J, *Fredericksburg*
Toner, James Patrick, *Norfolk*
Tran, De Dinh, *Falls Church*
Treherne, Robert Morton, *Chesapeake*
Treichler, Howard P, *Falls Church*
Tsapos, Michael J, *Annandale*
Tudder, Paul A, *Leesburg*
Turner, Frank Graber, *Danville*
Turner, John Mills III, *Farmville*
Turner, Philip, *Virginia Beach*
Turner, Ulysses G III, *Free Union*
Tyler, David, *Waynesboro*
Updike, Glenn B Jr, *Danville*
Uy, Flaviano O, *Chesapeake*
Uy, Gregorio C, *Chesapeake*
Valenti, Branko Sergio, *Annandale*
Valentine, Richard N Jr, *Virginia Beach*
Vamvanij, Somi Marie, *Hampton*
Van Der Woude, Harmen, *Vienna*
Van Dorsten, James Peter, *Richmond*
Vaughan, Ward Pierman, *Winchester*
Vaughan, Yolanda Kornegay, *Richmond*
Vermillion, Robert L, *Roanoke*
Vest, Gayle S, *Big Stone Gap*
Via, James Dillard, *Norfolk*
Vidarte, Joseph D, *Portsmouth*
Visscher, Harrison C, *Falls Church*
Visscher, Liliana Graciela, *Richmond*
Vitsky, Maurice Sidney, *Richmond*
Vogel, Scott Durand, *Charlottesville*
Vyas, Vishnu Keshavlal, *Lynchburg*
Wade, Karen Elizabeth, *Newport News*
Wagner, William Edward, *Richmond*
Walk, J Frederick, *Winchester*
Walters, Philip G, *Springfield*
Ward, Horace Greeley Jr, *Norfolk*
Ward, Phillip Dare, *South Boston*
Ware, Charles Ingersoll, *Gloucester*
Ware, Harry Hudnall III, *Richmond*
Warner, Michael R, *Manassas*
Warren, Bertram Lee, *Virginia Beach*
Warshauer, Sanford, *Alexandria*
Warsof, Steven L, *Norfolk*
Wash, Thomas Atwood, *Newport News*
Wasserman, L Leslie Jr, *Virginia Beach*
Waters, Louis N, *Chesapeake*
Watlington, Leigh Ellen, *Arlington*
Weishaar, Richard Jay, *Machipongo*
Weisshaar, Paul Howard, *Burke*
Werner, Glenn L, *Norfolk*
Wertheim, Ray Allen, *Fairfax*
Wetchler, Stewart J, *Newport News*
Whibley, Theresa W, *Norfolk*
White, Keith Clark, *McLean*
White, Rolfe D, *Virginia Beach*
Whitten, C Larry, *Harrisonburg*
Wilds, Preston L, *Norfolk*
Wilkes, Charles A, *Norfolk*
Willard, Richard Norman, *Virginia Beach*
Willey, John Boyd, *Winchester*
Williams, Aaron Trent, *Virginia Beach*
Williams, Annie L, *Norfolk*
Williams, David L, *Virginia Beach*
Williams, Louis H, *Richmond*
Willie, James Oliver, *Norfolk*
Willoughby, Michael Hill, *Leesburg*
Wilson, Lester A Jr, *Charlottesville*
Winn, Thomas M Jr, *Roanoke*
Winn, Washington Carlyle, *Richmond*
Winston, William O, *Portsmouth*
Winston, York E, *Virginia Beach*
Winter, Curtis Andrew, *Winchester*
Wisgirda, Jean Alice, *Reston*
Wisman, William Robert, *Roanoke*
Witherspoon, John M, *Richmond*
Witmer, Daniel G, *Harrisonburg*
Witt, Frederick J, *Portsmouth*
Wolanski, Edward T, *Charlottesville*
Wolcott, Hugh Dixon, *Virginia Beach*
Wolcott, James M Jr, *Norfolk*
Wood, Harriett E, *Newport News*
Woraratanadharm, S, *Richmond*
Word, Benjamin Harrison, *Charlottesville*
Wu, Shue Chen, *Portsmouth*
Young, David E, *Richmond*
Young, Diane Louise, *Fairfax*
Young, Lawrence D, *Newport News*
Young, Robert Ellsworth Jr, *Warrenton*
Zedler, Peter Alfred, *Richmond*
Zibdeh, Isam Tawfique, *Norton*
Zimberg, Stephen, *Suffolk*
Zimmerman, Charles H Jr, *Hampton*
Zirkle, Walter M Jr, *Harrisonburg*

Occupational Medicine

Ashby, Franklyn Henry, *Richmond*
Bates, Harry Clark Jr, *Rixeyville*
Bowen, John R Jr, *Richmond*
Clark, Frederick A Jr, *Richmond*
Davis, Robert E, *Virginia Beach*
Ford, George W, *Roanoke*
Gatzek, Werner J, *Richmond*
Harmon, James Alexander, *Newport News*
Harnsberger, James Power, *Hot Springs*
Inslee, Donald Ole, *Richmond*
Irby, Edward Claiborne, *Richmond*
Jackson, Gustavus V Jr, *Richmond*
Jensen, Warren Douglas, *Reston*
Jeremiah, John Spencer, *Salem*
Lawton, George Marion, *Luray*
Layton, James Edward, *Martinsville*
Lenthall, Ronald C, *Williamsburg*
Mac Millan, James M, *Richmond*
Mc Keown, Charles E, *Richmond*
Porter, George William Jr, *Richmond*

Occupational Medicine *(cont'd)*

Ragione, Joseph A, *Roanoke*
Reese, William Henry Jr, *Sterling*
Sasser, Frank M Jr, *Richmond*
Sherman, Janette Dexter, *Alexandria*
Sinclaire, Harry Addison, *Middleburg*
Stadulis, Jerome M, *Waynesboro*
Stallard, Clinton W Jr, *Newport News*
Stoeckel, Jay Edwin, *Waynesboro*
Sutphin, Adney Kemple, *Richmond*
Swotinsky, Robert Brian, *Alexandria*
Watts, Earl Wilson, *Salem*
Woodhouse, Robert W III, *Richmond*

Ophthalmology

Abedi, Shahla Alemi, *Midlothian*
Abedi, Shahla Asl, *Richmond*
Abela, Augusto V, *Woodbridge*
Allen, Robert C, *Charlottesville*
Altamirano, Rene, *Vienna*
Anderson, William C Jr, *Winchester*
Anselmi, Kenneth E, *Doran*
Armani, Michael Henry, *Alexandria*
Atlas, Barry Foster, *Portsmouth*
Atlas, Walter Gerard, *Richmond*
Awan, Khalil Javed, *Norton*
Bain, James Britton, *Waynesboro*
Baker, Robert E, *Portsmouth*
Baldinger, John Charles, *Fairfax*
Barmak, Leonard George, *Burke*
Barta, Joseph A Jr, *Radford*
Belevetz, David Roger, *Springfield*
Blair, Charles Joseph, *Richmond*
Bocknek, M Mendel, *Annandale*
Bodner, Bruce Ira, *Norfolk*
Bowles, James William, *Petersburg*
Brear, David Russell, *Culpeper*
Brock, Lee Richard, *Fredericksburg*
Brooks, Martha Jane, *Charlottesville*
Brown, James La Velle, *Richmond*
Brownlow, Robert Lee, *Arlington*
Bryce, Edwin Clinton II, *Richmond*
Bullock, J Paul Jr, *Richmond*
Bundy, Walter E III, *Richmond*
Bunting, Richard Fry, *Williamsburg*
Burns, Charles Leon Jr, *Winchester*
Burton, Calvin Thomas, *Irvington*
Butler, Geonard F, *Arlington*
Butrus, Salim Iliyya, *Salem*
Caine, Robert A, *Fredericksburg*
Caldwell, John Beale H, *Richmond*
Callahan, Flinton II, *Leesburg*
Campana, Jorge Luis, *Fairfax*
Campell, Henry S, *Martinsville*
Campochiaro, Peter A, *Charlottesville*
Caplen, Clifford W, *Staunton*
Capstack, Ronald E, *Harrisonburg*
Carlson, Richard Edward, *Norfolk*
Carney, Marcia D, *Richmond*
Carter, Bruce Thomas, *Charlottesville*
Childrey, Edgar Jr, *Urbanna*
Choi, Chung Shin, *Fairfax*
Chow, David K, *McLean*
Cobble, Clark Robert, *Danville*
Coleman, Howe Reese, *Lexington*
Coleman, William Peach, *Fredericksburg*
Combs, James L, *Richmond*
Combs, Luke, *Charlottesville*
Connors, Paul J, *McLean*
Conrad, Frederick Ellison, *Abingdon*
Conway, Brian Peter, *Charlottesville*
Cook, Gary Ruane, *Fairfax*
Cooper, Geoffrey G, *Richmond*
Cowley, Marianne Hardy, *Charlottesville*
Crews, Stanley Lloyd, *Virginia Beach*
Crigler, F Jason, *Charlottesville*
Crossen, Robert John, *Williamsburg*
Crouch, Earl Russell Jr, *Virginia Beach*
Crowgey, Junius Ellett, *Roanoke*
Crum, Jerry Brice, *Roanoke*
Cube, Ernesto Milla, *Radford*
Currier, Carol Anne, *Sterling*
Dabney, Thomas Todd Jr, *Richmond*
Dalton, H T, *Arlington*
Dannemann, Andrew Frederic, *Charlottesville*
Davis, F Sterling Jr, *Richmond*
Davis, Frederick Sterling, *Richmond*
De Bara, Roberto Julio, *Springfield*
Dickerson, John William, *Norfolk*
Dillon, Ronald Williams, *Salem*
Dotson, Richard L, *Alexandria*
Dressler, Linda Bubernak, *Fairfax*
Drysdale, Daniel B, *Blacksburg*
Duggan, Paul M, *Vienna*
Duong, Hon Q, *Fairfax*
Du Prey, Robert Edward, *Kilmarnock*
Eberdt, Arthur Jackson, *Williamsburg*
Echols, Porter Burks, *Lynchburg*
Echols, Porter Burks Jr, *Lynchburg*
Edmonds, John Thomas, *Accomac*
Egan, Brian, *Arlington*
Egge, Alan Chester, *Manassas*
Eggleston, Robert Bolling, *Harrisonburg*
Egleston, Du Bose, *Rockbridge Baths*
Eisele, Nancy Barbara, *Winchester*
Ellyn, Nicholas, *Alexandria*
Evans, Peter Y, *Falls Church*
Falls, Richard Alfred, *Vienna*
Faris, Bishara M, *McLean*
Farley, Jimmy W, *Roanoke*
Ferry, Andrew P, *Richmond*
Fink, Alan Jeffrey, *Front Royal*
Fjordbotten, Alf Lee, *Arlington*
Fogle, Kelly Ashworth, *Richmond*
Foley, John Albert, *Nassawadox*
Fox, Kenneth Richard, *Arlington*
Framm, Daniel Herschel, *Vienna*
Framm, Lisa Gale, *Vienna*
Frantz, John F, *Newport News*
Fraser, Douglas J Jr, *Springfield*
Freda, Franklin Lawrence, *Hampton*
Freed, Charles Conrad Jr, *Danville*
Frey, Thomas, *Falls Church*
Fyffe, Deborah Lynn, *Falls Church*
Gardner, Richard Ernest, *Staunton*
Gaspar, Maurice L, *Arlington*
Gazala, Joseph R, *Richmond*
Geisert, Todd W, *Gloucester*
Gilbert, William Steven, *Vienna*
Gillespie, Albert R, *Staunton*
Gillespie, James E, *Waynesboro*
Gillespie, John N II, *Petersburg*
Gilligan, John Henry Jr, *Alexandria*
Glover, C Kinsey, *Fredericksburg*
Goldberg, Michael Harvey, *Springfield*
Goldmann, Peter Herbert, *Richmond*
Grantham, Richard Lee, *Winchester*
Grayson, Donald M, *Martinsville*
Griffey, Richard Thomas, *Norfolk*
Gruber, Michael Anthony, *Annandale*
Guelzow, Kurt W L, *Roanoke*
Guerry, Du Pont III, *Richmond*
Guerry, Richard Kennon, *Richmond*
Hamby, Debra A, *Newport News*
Hamidi Toosi, Shakur, *Norfolk*
Hankins, George S, *Newport News*
Hannon, John F, *Falls Church*
Hansen, Kenneth Dale, *Arlington*
Harkrader, James C, *Richmond*
Harman, David M, *Lynchburg*
Harris, Ronald B, *Roanoke*
Harvan, David, *Manassas*
Harvey, Charles Thomas, *Danville*
Hatcher, William F, *Roanoke*
Heatwole, Eugene W, *Newport News*
Helms, Lee Thomas, *Roanoke*
Henry, Conrad Allan, *Norfolk*
Hensle, Craig L, *Woodbridge*
Heyner, Gregory James, *Richmond*
Hines, Michael John, *Hampton*
Hobbs, Frank I, *Lynchburg*
Hobbs, William Alexander Jr, *Lynchburg*
Hoskins, Horace D, *Lynchburg*
Huberman, Richard, *Alexandria*
Humphrey, William Trowell, *Norfolk*
Humphries, Marion K III, *Roanoke*
Humphries, Marion K Jr, *Charlottesville*
Hutt, James B Jr, *Warrenton*
Jacey, Robert Wayne, *Richmond*
Johnson, Hal S, *Richmond*
Johnson, W Rayner, *Winchester*
Johnston, Robert M, *Leesburg*
Jones, Orvin C, *Newport News*
Kaltreider, Sara Alice, *Richmond*
Kanal, Nirmal, *Front Royal*
Karickhoff, John Robert, *Falls Church*
Karlin, Kenneth M, *McLean*
Katzen, Jay E, *Alexandria*
Keenan, Thomas P, *Winchester*
Kiesel, Robert D, *Arlington*
King, Robert Garland Jr, *Richmond*
Kinsler, David A, *Salem*
Kiser, William David, *Marion*
Kling, Robert P, *Falls Church*
Klotz, Jeremiah A Jr, *Norfolk*
Lamarche, Donald Edward, *Virginia Beach*
Lanter, David Lloyd, *McLean*
La Roche, Ripon W II, *Farmville*
Lawson, Edgar Clifford, *Charlottesville*
Layman, Paul R, *Newport News*
Lederman, Ira Robert, *Norfolk*
Lee, Parker Hall Jr, *Lynchburg*
Lee, Rory Tsang, *McLean*
Legge, Withrow Reynolds Jr, *Winchester*
Le Peter, Alan Joseph, *Roanoke*
Leslie, Evan Joel, *Richmond*
Leto, Carl J, *Vienna*
Levy, Phillip Morton, *Newport News*
Limaye, Suresh R, *Falls Church*
Littlefield, Jerald J, *Alexandria*
Lotano, Remo Andrea, *Lynchburg*
Luague, Samuel B, *Galax*

Ophthalmology *(cont'd)*

Macdonald, Roderick Jr, *Richmond*
Mac Ilwaine, William Andrew, *Charlottesville*
Mac Millan, David W, *Richmond*
Mac Phail, Joseph C, *Portsmouth*
Madden, Willis Mcdonald, *Petersburg*
Magovern, Malcolm J Jr, *Richmond*
Malone, Timothy J, *Great Falls*
Manguikian, Dertad, *Fairfax*
Maoury, Stanley D, *Manassas*
Marak, George E Jr, *Alexandria*
Marshall, Hubert A Jr, *Charlottesville*
Martin, Gerry David, *Waynesboro*
Maxey, Ellis F, *Newport News*
Mayer, Walter, *Richmond*
Mc Ateer, Mary Beth, *Falls Church*
Mc Coy, Cullen M, *Norfolk*
Mc Farland, Scott Taylor, *Fairfax*
Mc Kee, Brian J, *Newport News*
Mc Neer, Keith W, *Richmond*
Mc Neer, Paul R, *Richmond*
Mears, William Warren, *Lexington*
Meyer, Russell, *Virginia Beach*
Miller, Calvin Lewis, *Abingdon*
Mills, Dawson A, *Fredericksburg*
Moayery, Massoum, *Virginia Beach*
Moll, Anthony T, *Newport*
Mono, Jeffrey Alan, *Alexandria*
Moore, Patrick David, *Newport News*
Morgan, Walter Edward III, *Petersburg*
Mullen, P Wesley, *Richmond*
Myers, Boyd Douglas, *Falls Church*
Neatrour, George P, *Virginia Beach*
Neidlinger, Robert Walter, *Springfield*
Newby, William Edward, *Virginia Beach*
Newman, Steven Alan, *Charlottesville*
Nicholas, Ellyn, *Alexandria*
Notes, David Raymond, *Fairfax*
Nowell, John Francis, *Arlington*
Oberhoff, Peter, *McLean*
O'Dwyer, Andrew J Jr, *Chesapeake*
Oppenheim, Seth Herbert, *Newport News*
Oshinsky, Arnold L, *Falls Church*
Outen, Carl D, *Richmond*
Parelhoff, Edward S, *Woodbridge*
Pearlman, Edwin, *Norfolk*
Peay, Clifton Lawrence, *Richmond*
Perkins, Edward W, *Richmond*
Perraut, Louis Edward Jr, *Vienna*
Perraut, Louis Edward Sr, *Vienna*
Petras, Christodoulos M, *Richmond*
Phillips, James W, *Newport News*
Pietsch, Richard Lake, *Crozet*
Pilkerton, Arthur Raymond Jr, *Vienna*
Popkin, Arnold B, *Charlottesville*
Posner, Irvin L, *Norfolk*
Preston, Robert Willard, *Harrisonburg*
Race, Donald John, *Roanoke*
Reda, Annette Williams, *Norfolk*
Redding, Marshall S, *Norfolk*
Reshefsky, Bonnie Louis, *Norfolk*
Reuling, Frank Harold Jr, *Winchester*
Reynolds, Arthur M Jr, *Lorton*
Rice, Robert D E, *Glen Allen*
Rich, Petrovia Morgan, *Richmond*
Rich, William L III, *Falls Church*
Richards, David William, *Richmond*
Richardson, Peter B, *Staunton*
Richman, Donald William, *Martinsville*
Riggs, Patrick Kelly, *Norfolk*
Robinson, Joy Dixon, *Hampton*
Roebuck, Jerome Barland, *Petersburg*
Romaine, Charles N, *Richmond*
Roper, Barry Edward, *Richmond*
Rosende, Carlos Alberto, *Portsmouth*
Rusher, William De Witt, *Richmond*
Saeed, Tariq, *South Boston*
Sakowski, Anthony D Jr, *Richmond*
Sankar, Krishna, *Covington*
Schott, Louis Joseph, *Norfolk*
Schumann, Deborah J, *Burke*
Schwartz, Anne Catherine, *Springfield*
Scott, Pierre Brutsche, *Alexandria*
Seidman, David Jay, *Falls Church*
Sen, Harsha Ananda, *Charlottesville*
Sheppard, John Daniel Jr, *Virginia Beach*
Sheridan, Andrew J, *Arlington*
Sherrill, Richard W, *Norfolk*
Shortridge, Charles M, *Roanoke*
Singer, Lewis Jay, *Roanoke*
Singh, Parbhur, *Virginia Beach*
Smith, Brent Elliot, *Petersburg*
Smith, Lindley T, *Richmond*
Smith, Mason, *Richmond*
Smith, Patricia Walsh, *Charlottesville*
Sowers, Ann B, *Roanoke*
Spellman, Steven G, *Newport News*
Spence, George David, *Charlottesville*
Sponaugle, Harlan Dale, *Portsmouth*
Starling, Jay C, *Portsmouth*
Stathos, John A Jr, *Staunton*
Stevens, Garth Jr, *Richmond*
Stingl, Daniel Mark, *McLean*
Stone, Kearfott Mc Caull, *Gloucester*
Stone, William Conrad, *Roanoke*
Stratford, Thomas Peirson, *Richmond*
Suarez, Alfred Jr, *Fairfax*
Sudranski, Herbert F, *Roanoke*
Summer, David B, *Alexandria*
Summers, John T Jr, *Richmond*
Sunga, Roberto N, *Vienna*
Suttenfield, Charlie M, *Lynchburg*
Svoboda, Joseph Robert, *Richmond*
Talegaonkar, S K, *Hopewell*
Taylor, Harry B Jr, *Norfolk*
Taylor, Waller L Jr, *Virginia Beach*
Taylor, William Wickham, *Norfolk*
Till, Jonathan Stanwood, *Salem*
Timmes, Joseph John Jr, *Annandale*
Toosi, S H, *Norfolk*
Traboulsi, Elias Iskandar, *Arlington*
Tran, Hoa Dinh, *Hampton*
Trant, John H III, *Virginia Beach*
Trice, E Winston, *Richmond*
Trimber, Connell James, *Alexandria*
Tuck, Kenneth Douglas, *Roanoke*
Valdivieso, Jorge R, *Portsmouth*
Valone, James Austin Jr, *Norfolk*
Volk, Stephan C, *Richmond*
Von Fricken, Manfred A, *Fairfax*
Waddell, Marion Crockett, *Richmond*
Wagner, Alan Lewis, *Virginia Beach*
Watson, Bruce Allen, *Salem*
Watson, Marion Howell, *Danville*
Webb, Robert B Jr, *Petersburg*
Weiler, Harold Hauser, *Virginia Beach*
Weinberg, Richard J, *Vienna*
Weinberg, Robert Stephen, *Richmond*
Whisnant, Robert A, *Lynchburg*
White, David W, *Lynchburg*
Whitelock, Leland D Jr, *Norfolk*
Whitworth, Claiborne G, *Charlottesville*
Wiesinger, Herbert, *Richmond*
Wilkins, Howard B, *Portsmouth*
Williams, Frederick M, *Virginia Beach*
Williams, Richard K, *Richmond*
Willis, Amos Johns, *Fredericksburg*
Wilson, Charles S, *Farmville*
Winn, Thomas M, *Roanoke*
Woo, Hong Yooke, *Suffolk*
Wood, John Robert, *Roanoke*
Woodroof, Kerry C, *Bedford*
Wright, James C, *Virginia Beach*
Wry, Diane J, *Norfolk*
Wyatt, Davis Burton, *Richmond*
Yassin, John Gerald, *Falls Church*
Yoder, Paul Roy Jr, *Harrisonburg*
Youssefi, Bijan, *Arlington*
Zeavin, Bernard H, *Alexandria*

Orthopedic Surgery

Abbott, Paul J, *Virginia Beach*
Abbott, Paul Jerome Jr, *Virginia Beach*
Adelaar, Robert S, *Richmond*
Aland, Christopher Martin, *Springfield*
Albers, William Eric, *Lynchburg*
Albrigo, John L, *Arlington*
Alexander, Edward G Jr, *Alexandria*
Allan, J Hamilton, *Charlottesville*
Allen, Benjamin F, *Culpeper*
Allen, Harold Hayes Jr, *Sterling*
Amundson, Glenn Martin, *Portsmouth*
Andersen, Charles Frederic, *Waynesboro*
Andrews, William C Jr, *Lynchburg*
Anthony, Scott B, *Richmond*
Antonio, David R, *Kilmarnock*
Antoun, Adel Louis, *Woodbridge*
Archer, Lorenzo Pharr, *Norfolk*
Archibald, Ian D, *Clifton Forge*
Armstrong, Thomas Smith, *Irvington*
Avery, Gordon Lee, *Arlington*
Ayres, John W, *Richmond*
Azer, Rida N, *Alexandria*
Azer, Samir N, *Alexandria*
Barranco, S D, *Blacksburg*
Barrick, E Frederick, *McLean*
Beatie, William Edward, *Alexandria*
Belcher, Rodney L, *Arlington*
Benavides, Jaime Miguel, *Fishersville*
Bendigo, Leopoldo Lopez, *Richlands*
Bhuller, Gurpal S, *Hopewell*
Bigley, Elmer C Jr, *Alexandria*
Blackburn, James E, *Lynchburg*
Blasdell, Steven C, *Portsmouth*
Blumberg, Kalman David, *Richmond*
Boatright, Kenneth A, *Waynesboro*
Bosse, Michael Joseph, *Chesapeake*
Bowen, Robert R, *Lynchburg*
Bowman, John David, *Richmond*
Bray, Charles B Jr, *Roanoke*
Brickhouse, William Darnell, *Richmond*
Brown, Christopher J, *Warrenton*

Orthopedic Surgery *(cont'd)*

Brown, Thomas Montford, *Christiansburg*
Bruno, John A Jr, *Alexandria*
Bruno, Peter D, *McLean*
Bryan, Hugh Mclellan III, *Gloucester*
Burgess, David Arnold, *Waynesboro*
Burkhardt, Barry W, *Richmond*
Burns, Francis Gregory Jr, *Virginia Beach*
Butler, Bruce Jr, *Alexandria*
Butterworth, John F III, *Richmond*
Butterworth, Thomas R, *Richmond*
Byrd, J Abbott III, *Virginia Beach*
Cabrera, Ruben D, *Fairfax*
Caffrey, William Daniel, *Richmond*
Cantin, Ira M, *Norfolk*
Cardea, John Alexander, *Richmond*
Carmines, Fay Ashton, *Newport News*
Carpenter, Earnest B, *Richmond*
Carrigan, Edward P, *Richmond*
Carroll, Shelia Elizabeth, *Falls Church*
Casabona, Albert C, *Fairfax*
Caspari, Richard B, *Richmond*
Cassidy, Michael P, *Annandale*
Catallozzi, Kenneth Rocco, *Hampton*
Chand, Yogesh, *Bluefield*
Chandra, Ramesh Gattu, *Fairfax*
Chappell, George E Jr, *Harrisonburg*
Choban, Stephen J, *Virginia Beach*
Cicoria, Anthony David, *Charlottesville*
Clark, Mary Williams, *Charlottesville*
Clarke, John Paul, *Roanoke*
Clary, Beverley B, *Richmond*
Clements, Ernest L Jr, *Richmond*
Coccia, Tullio L, *Danville*
Cohen, Lawrence, *Sterling*
Cohen, Lawrence F, *Richmond*
Collier, J C Porter, *Portsmouth*
Couk, David Edgar, *Warrenton*
Covino, Brian Mark, *Charlottesville*
Craun, Galen G Jr, *Harrisonburg*
Crickenberger, Dallas P, *Roanoke*
Crosier, Joseph L, *Petersburg*
Dalton, Gordon Vincent, *Richmond*
Dalton, James B Jr, *Richmond*
Danaceau, Henry Lawrence, *Arlington*
Daniels, Kennedy S, *Richmond*
Dannelly, Edward A III, *Galax*
Dart, Robert C, *Warrenton*
Daugherty, Thomas W, *Boyce*
Davalos, Hugo A, *Alexandria*
Davidson, Donald Dale, *Richmond*
Davidson, Stuart L, *Alexandria*
Deafenbaugh, Martin Keith, *Chesapeake*
De Blasi, Robert F, *Fredericksburg*
De Blois, Mark Edwin, *Midlothian*
Debs, Anthony, *Manassas*
Delenick, Peter J, *Alexandria*
Derian, Paul S, *Marion*
Devereux, James Peter, *Norfolk*
Deyerle, William Minor, *Richmond*
Dick, W Barton, *Lexington*
Dingle, Donald Moitie, *South Boston*
Dobranski, Andrew I, *Annandale*
Dobson, John Lynn, *Virginia Beach*
Donnelly, Kerry Bruce, *Richmond*
Dorsey, Thomas Reid, *Newport News*
Dowlatshahi, Abdol Hossein, *Virginia Beach*
Dubovsky, Elizabeth Carol, *Dumfries*
Dugdale, Thomas William III, *Chesapeake*
Dunstan, James C Jr, *Lynchburg*
Du Puy, Theodore E, *Chesapeake*
Durham, Alfred A, *Roanoke*
Durica, David L, *Portsmouth*
Eelma, Jean Matthees, *Richlands*
Eglevsky, Andre Jr, *Fredericksburg*
Elkins, Robert W, *Danville*
Elmore, Stanley Mcdowell, *Richmond*
Emich, Charles Henry, *Alexandria*
Engh, Charles A, *Arlington*
Engh, Gerard A, *Arlington*
Eschenroeder, H C Jr, *Lynchburg*
Faludi, Dezso Dennis, *Alexandria*
Favareau, James E, *Front Royal*
Felder, David Arthur Jr, *Hampton*
Ferguson, W R, *Colonial Heights*
Fiore, Steven Mark, *Richmond*
Fisher, Richard Harding, *Salem*
Fithian, Thomas E, *Newport News*
Fitzgerald, Paul Francis, *Lynchburg*
Fleeter, Thomas B, *Reston*
Fleming, William Kermit, *Richmond*
Ford, Gregory Martin, *Burke*
Foster, James Edward, *Lynchburg*
Foster, William Christopher, *Midlothian*
Fox, Frederick Louvane, *Harrisonburg*
Frank, William E, *Lynchburg*
Freeman, Glenn Joseph, *Richlands*
Freund, Ronald Kenneth, *Virginia Beach*
Gaertner, Richard L Jr, *Vienna*
Gardner, James L, *Abingdon*
Gardner, William Vaughn, *Charlottesville*
Garnett, L W, *Richmond*
Gaughan, Robert T, *Alexandria*
Gazale, William J, *Fairfax*
Giannotto, Richard P, *Chesapeake*
Gilbert, James B, *Alexandria*
Glaser, John Arthur, *Charlottesville*
Glassman, Andrew H, *Arlington*
Gluck, Gabriel, *Manassas*
Gold, Edward William, *Virginia Beach*
Grasinger, John E, *Williamsburg*
Gray, Kenneth Wayne, *Radford*
Greene, Arthur D, *Hampton*
Gross, Alton F, *Danville*
Guerrero, Victor N, *Manassas*
Habeeb, Edward David, *Chesapeake*
Hadden, David Charles, *Marion*
Hagan, Hugh J III, *Roanoke*
Haines, David Morrill, *Petersburg*
Hakala, Edwin Wayne, *Richmond*
Hakala, Michael W, *Richmond*
Hall, Nelson, *Williamsburg*
Hamilton, Colin W, *Virginia Beach*
Haney, Ronald Loyde, *Farmville*
Hanff, William A, *Alexandria*
Harrington, F Baldwin, *Fredericksburg*
Harrison, Carrington III, *Staunton*
Hartman, Michael James, *Roanoke*
Hawken, Samuel M, *Annandale*
Haworth, Charles Stephenson, *Charlottesville*
Hazel, William A Jr, *Herndon*
Heilen, Robert J, *Annandale*
Heiman, Melvin L, *Abingdon*
Henceroth, William D II, *Richmond*
Henderson, Walter T, *Richlands*
Henning, George D, *Roanoke*
Hess, Irvin Eugene, *Harrisonburg*
Holcomb, Harry Sherman III, *Franktown*
Holden, Richard Theodore, *Chesapeake*
Holm, Richard Philip, *Franklin*
Hoover, Milton J Jr, *New Kent*
Hopkins, Jay Everett, *Lynchburg*
Howell, Donald S, *Suffolk*
Hulvey, J Thomas, *Abingdon*
Hussey, Robert William, *Richmond*
Irby, Edward C Jr, *Richmond*
Jackson, Charles B, *Great Falls*
Jackson, Hampton J Jr, *Alexandria*
Jackson, Kenneth William, *Chantilly*
Jacobson, Peter C, *Virginia Beach*
Jamali, Alireza, *Chesapeake*
James, Charles Marion, *Richmond*
Jessee, Samuel Davidson, *Richmond*
Jessup, Douglas E, *Richmond*
Johnson, John Walter, *Fredericksburg*
Johnson, Marriott C Jr, *Fredericksburg*
Johnson, Wayne T, *Portsmouth*
Johnstone, William T, *Richmond*
Jones, James Barrett, *Lynchburg*
Jones, Steven H, *Richmond*
Jordan, Louis R, *Norfolk*
Joubin, Jahan M, *Woodbridge*
Kana, Stephen Michael, *Alington*
Kaplan, Saul J, *Annandale*
Kavanagh, Michael Andrew, *Leesburg*
Kavjian, David Alan, *Alexandria*
Kaye, Joseph T, *Alexandria*
Keffer, Ernest J Jr, *Roanoke*
Kells, Douglas U, *Suffolk*
Killian, John Thomas, *Portsmouth*
Kirk, Arthur Abbitt, *Portsmouth*
Klein, Thomas Joseph, *Burke*
Knauft, Richard David, *Portsmouth*
Kotay, S C, *Wise*
Koulizakis, E N, *Annandale*
Kovac, Michael John Jr, *Charlottesville*
Kovacic, Joseph H, *Colonial Heights*
Kramer, Stuart J, *Danville*
Krop, Paul Nicholas, *Virginia Beach*
Kulund, Daniel N, *Charlottesville*
Kyles, Michael K, *Richmond*
Lambdin, Charles S, *Portsmouth*
Lane, H Edward III, *Falls Church*
Lane, Herbert E Jr, *Falls Church*
Langloh, John Thomas, *Arlington*
Lannik, David E, *Portsmouth*
Lapkass, John Eugene, *Charlottesville*
Leabhart, John William Jr, *Alexandria*
Leadbetter, Mark Renton, *Staunton*
Lefton, Charles Stuart, *Vienna*
Lehman, Robert F, *Manassas*
Levin, Stephen M, *Alexandria*
Liebrecht, Paul C, *Galax*
Lindsey, Wayne Cornell, *Alexandria*
Linehan, Joseph David Jr, *McLean*
Lipscomb, Larry G, *Marion*
Lithgow, William C, *Midlothian*
Lochmann, Daniel Paul, *Virginia Beach*
Loughran, Thomas Patrick, *Richmond*
Loxley, Sidney S, *Chesapeake*

Orthopedic Surgery *(cont'd)*

Lublin, Bernard A, *Richmond*
Lucey, John D, *Fredericksburg*
Mac Mahon, Edward B, *Middleburg*
Mac Carty, William C III, *South Boston*
Mac Ilwaine, John Courtenay, *Staunton*
Mackay, S Ross, *Blacksburg*
Mackler, Stuart F, *Radford*
Mac Nay, Donald L, *Manassas*
Macys, Joseph R, *Richmond*
Madden, Mark Patrick, *Arlington*
Mahinpour, Siavash, *Falls Church*
Malka, Jeffrey S, *McLean*
Malone, Jonathan K, *Harrisonburg*
Maltry, John Arthur, *Norfolk*
Manning, James Bentley, *Richmond*
Marcus, Norman A, *Springfield*
Markham, Thomas Carl, *Norfolk*
Martenson, Stephen Hudnall, *Winchester*
Martinelli, Thomas Albert, *Alexandria*
Mason, Joel A, *Norfolk*
Masterson, James H, *Falls Church*
Mathews, Hallett H, *Richmond*
Mauck, William R, *Richmond*
Maximous, Talaat Fahmy, *Alexandria*
May, Virgil R Jr, *Richmond*
Mc Carthy, Harry Smith, *Newport News*
Mc Connell, John P, *Arlington*
Mc Coy, Stephen H, *Norfolk*
Mc Glynn, Fred J, *Richmond*
Mc Guire, Robert Alton Jr, *Chesapeake*
Mc Hale, Kathleen Ann, *Franconia*
Mc Kain, Carey W, *Abingdon*
Mc Kenzie, Thomas Peter, *Mechanicsville*
Mc Laughlin, Robert E, *Charlottesville*
Mc Leod, James W, *Roanoke*
Mc Shane, Elizabeth Jane, *Charlottesville*
Meade, Thomas S Jr, *Virginia Beach*
Meyers, John Fredrick, *Richmond*
Miller, Charles Willard, *Charlottesville*
Miller, Terry Oliver, *Lynchburg*
Miller, Thomas K, *Roanoke*
Mirenda, William M Jr, *Roanoke*
Mjos, Timothy A, *Kilmarnock*
Moga, David Benjamin, *Charlottesville*
Molligan, Harry J, *Norfolk*
Moore, Jeffrey Dean, *Richmond*
Morales, Lawrence R, *Chesapeake*
Morina, John Michael, *Virginia Beach*
Moskal, Joseph T, *Roanoke*
Moss, John Simpson, *Fredericksburg*
Mull, Sears Curtiss, *Salem*
Mullins, William J, *Newport News*
Munters, Manfreds, *Alexandria*
Murari, Timeri Mahinder, *Fairfax*
Musgrave, Robert E, *Danville*
Myers, Alonzo H, *Roanoke*
Nachman, Herman M, *Richmond*
Neff, Robert S, *Norfolk*
Nejad, G A, *Woodbridge*
Nevins, Kerry Francis, *Newport News*
Nichols, Glenn W, *Chesapeake*
Nirschl, Robert P, *Arlington*
Noer, Harold Rolf, *Falls Church*
Nogi, Jay, *Richmond*
O'Brien, Denis Peter, *Arlington*
O'Brien, Michael B, *Fredericksburg*
O'Connell, Patrick William, *Virginia Beach*
O'Neill, Donald A, *Virginia Beach*
Ormandy, Laszlo, *Falls Church*
O'Rourke, Franklyn Sewall, *Salem*
Packer, Bernard D, *Richmond*
Paik, Seung W, *Fairfax*
Palumbo, Pasquale M, *Vienna*
Panagis, James S, *Reston*
Perlmutter, Jack B, *Culpeper*
Perry, Peter L, *Martinsville*
Persons, Jeffrey B, *Suffolk*
Pettrone, Frank A, *Arlington*
Phillips, James L, *Hampton*
Pilcher, Robert M Jr, *Richmond*
Platt, Joseph L, *Lynchburg*
Ploska, Philip Gregory, *Charlottesville*
Pluchinotta, Annibale Antonio, *Alexandria*
Pole, W Clarke, *Norfolk*
Poole, Robert William, *Kilmarnock*
Port, Teig, *Danville*
Porter, Ira Stanley, *Norfolk*
Pournaras, Stephen W Jr, *Fairfax*
Powell, Douglas O, *Newport News*
Prillaman, Henry A Jr, *Newport News*
Pruner, Robert A, *Roanoke*
Psimas, George N, *Portsmouth*
Punyanitya, Visespong, *Charlottesville*
Pupparo, Frank, *Alexandria*
Rabhan, Walter N, *Richmond*
Rahmati, Ardeshir, *Alexandria*
Rawles, John G Jr, *Richmond*
Reddy, G V, *Doran*
Redler, Michael Ross, *Charlottesville*
Reid, Bruce Walter, *Hampton*
Reinert, Charles Marshall, *Portsmouth*
Reing, C Michael, *Annandale*
Remuzzi, Robert, *Leesburg*
Rezba, Benjamin Victor, *Winchester*
Rhodes, Mark A, *Woodstock*
Richter, Geraldine, *Manassas*
Ripley, Louis Paul, *Roanoke*
Rodriguez, Oscar, *Alexandria*
Rogers, Charles L, *Annandale*
Rogers, Mark Randall, *Norfolk*
Romness, Joseph O, *Arlington*
Rook, Frederick W, *Annandale*
Rosario, Antonio, *Martinsville*
Routson, Gary W, *Richmond*
Russ, Clarke, *Virginia Beach*
Rutkowski, Robert, *Culpeper*
Ryder, Craig A, *Suffolk*
Salter, Fredric Louis, *Falls Church*
Saraiya, Sharad Kumar N, *Norton*
Sawmiller, Samuel Ray, *Springfield*
Schaffer, John Joseph, *Norfolk*
Schiffman, Joel H, *Alexandria*
Schildwachter, Thomas Legge, *Charlottesville*
Schreiber, Douglas R, *Virginia Beach*
Schulz, Thomas J, *Winchester*
Schwartz, James R, *Alexandria*
Seitz, Donald G, *Richmond*
Sellergren, Kim Roy, *Richmond*
Shaffer, Lee W Jr, *Roanoke*
Shaffer, Stephen Roger, *Arlington*
Shall, Lawrence M, *Norfolk*
Sharps, Chester H, *Richmond*
Sherman, Claude Porter, *Martinsville*
Sidhu, Baljit S, *Hopewell*
Siegel, Marc S, *Blacksburg*
Smith, Donald B, *Mechanicsville*
Smith, Mark A H Jr, *Richmond*
Smokvina, Drago, *Reston*
Snyder, David Michael, *Rixeyville*
Sparks, Paul Cornwell, *South Boston*
Spear, Curtis Varnell Jr, *Norfolk*
Spetzler, Bertram, *Salem*
Spiegler, Glenn Jay, *Tappahannock*
St Clair, Harvey Sheldon, *Norfolk*
Staeheli, John William, *Chesapeake*
Stamp, Warren G, *Charlottesville*
Stanton, Archie C, *Newport News*
St Clair, H Sheldon, *Norfolk*
Stephenson, Robert Brian, *Springfield*
Stern, Howard Gene, *Richmond*
Sternberg, Richard J, *Sterling*
Stiles, Thomas Marvin, *Newport News*
Strelka, Eugene P Jr, *Blacksburg*
Strider, David V, *Charlottesville*
Strong, Thomas E, *Roanoke*
Sussman, Michael David, *Charlottesville*
Swisher, Forrest M, *Alexandria*
Swope, Bernard M, *Winchester*
Sydnor, Robert W, *Lynchburg*
Tawfick, Mohammed A, *Petersburg*
Taylor, Gervas S Jr, *Nellysford*
Thiemeyer, John S Jr, *Norfolk*
Tiesenga, Sidney W, *Chesapeake*
Tornberg, David N, *Newport News*
Torre, Brian A, *Salem*
Traynham, John E III, *Hampton*
Tremaine, M D, *Arlington*
Trieshmann, Helmuth W, *Newport News*
Troup, James B, *Winchester*
Turner, Charles Wesley, *Danville*
Ubelhart, Charles Robert, *Alexandria*
Udupa, Sudhakara K R, *Wise*
Van Herpe, Leo Bryant, *Arlington*
Vanichkachorn, Sukri, *South Hill*
Vann, John A, *Virginia Beach*
Vaughan, Paul Alan, *Pulaski*
Verdin, Peter J Jr, *Alexandria*
Vitek, Brantley P, *Annandale*
Von Oesen, H Davis, *Lynchburg*
Waddell, Robert W, *Virginia Beach*
Wagner, John S, *Norfolk*
Walker, Thomas M, *Arlington*
Wang, Gwo-Jaw, *Charlottesville*
Ward, Kenneth G, *Woodbridge*
Wardell, Arthur W, *Portsmouth*
Watkins, Franklin P, *Richmond*
Webster, David K, *Swoope*
Webster, Mark D, *Newport News*
Weidman, Clare David, *Low Moor*
Weitzman, Gerald, *Portsmouth*
Wenkstern, Michael G, *Martinsville*
Whipple, Terry L, *Richmond*
White, Earl D II, *Hampton*
White, H George Jr, *Winchester*
White, Robert M, *Arlington*
Whitehill, Richard, *Charlottesville*
Widmeyer, Robert S, *Roanoke*
Wilhelm, Charles Edwin, *Williamsburg*
Williamson, John A, *Virginia Beach*
Williamson, Sterling R, *Norfolk*
Wilson, Jeffrey K, *Richmond*
Wise, Dennis W, *Winchester*

Orthopedic Surgery *(cont'd)*

Wombwell, Joseph H, *Lynchburg*
Worland, Richard L, *Richmond*
Yancey, Henry A, *Richmond*
You, Young Joon, *Alexandria*
Young, David B, *Norfolk*
Zilberfarb, Bernard, *Manassas*
Zimmer, Bruce Stuart, *Alexandria*
Zimmer, Timothy James, *Richmond*

Otolaryngology

Abedi, Esrafil, *Richmond*
Acevedo, Miguel A, *Alexandria*
Afify, Mohamad Ahmad, *Norfolk*
Ahmed, Mehboob, *Virginia Beach*
Almassian, H Peter, *Fairfax*
Amini, Massoud, *Arlington*
Amiri, Cyrus S, *Norfolk*
Archer, John S Jr, *Richmond*
Atiyeh, Wasfi A, *Richmond*
Atkinson, Elizabeth Ann, *Sterling*
Ballard, Peter Francis, *Abingdon*
Barr, Norman Lee Jr, *McLean*
Bell, Houston Lesher, *Roanoke*
Bellis, Morris Edgar, *Norton*
Biavati, Michael Joseph, *Charlottesville*
Bishop, William D, *Radford*
Bottone, Robert Francis, *Reston*
Burch, Gary R, *Vienna*
Burtoff, Bruce D, *Alexandria*
Burtoff, Samuel, *Alexandria*
Cachay, Antonio J, *Annandale*
Callari, Richard Henry, *Richmond*
Cantrell, Robert Wendell, *Charlottesville*
Catz, Nitzan D, *Arlington*
Centonze, John Frank, *Portsmouth*
Chiancone, Giancarlo, *Richmond*
Clark, Joe Lynn, *Lynchburg*
Clarke, William T, *Richmond*
Cole, John Jr, *Roanoke*
Collier, John R Jr, *Winchester*
Cowley, Larry Allen, *Blacksburg*
Crittenden, David Gray, *Richmond*
Cross, David L, *Manassas*
Dalton, Randall Elliott, *Richmond*
Davie, Steven Ames, *Blacksburg*
Dichtel, William J Jr, *Roanoke*
Dodd, Richard Wine, *Richmond*
Eagles, Donald Taylor, *Virginia Beach*
Eastham, R Jack III, *Charlottesville*
Eberhart, Jack Henry, *Martinsville*
Echols, William Beecher, *Lexington*
Evans, Olan N, *Richmond*
Ewell, Murlin Knox, *Afton*
Fairbanks, David Nathanial, *McLean*
Feinman, Maxwell Carlton, *Lynchburg*
Ferlazzo, Stephen L, *Woodbridge*
Fields, Richard L, *Fairfax*
Fischer, Ronald Allen, *Waynesboro*
Frable, Mary Ann Smith, *Richmond*
Freeman, Stephen Brent, *Chesapeake*
Gallucci, Charles Leonard, *Newport News*
Gates, C Wayne, *Harrisonburg*
Gelman, Howard K, *Fairfax*
Gill, John A, *Richmond*
Gilmer, Graham III, *Lynchburg*
Giordano, Anthony M, *Richmond*
Giunta, Stephen, *Alexandria*
Goldstein, Jerome Charles, *Arlington*
Goldstone, Alvin, *Richmond*
Grayson, Richard Joseph Jr, *Roanoke*
Greenberg, Milton, *Danville*
Hagadorn, Jon Bruce, *Salem*
Hager, Ewald J, *Alexandria*
Hakim, Arcadius H, *Alexandria*
Hanabury, Mark R Jr, *Roanoke*
Hanna, Stevan T, *Staunton*
Harrell, Gordon F, *Norfolk*
Harrington, Randall Leon, *Leesburg*
Harris, David Maxwell, *Bluefield*
Hayden, George Douglas, *Richmond*
Hengerer, James R, *Lynchburg*
Hermansen, Karen L, *Fairfax*
Hickman, Clifton C, *Richmond*
Huhn, John Frederick, *Charlottesville*
Hulcher, Julius C, *Richmond*
Iqbal, M Zafar, *Arlington*
Isaac, Bernard Anthony, *Leesburg*
Jackson, Anthony W, *Richmond*
Jackson, Robert T, *Norfolk*
Johnson, Charles M III, *Charlottesville*
Juhlin, Nancy Rae, *Alexandria*
Kalafsky, John T, *Norfolk*
Kelleher, Michael John, *Norfolk*
Kennedy, Kevin S, *Portsmouth*
Keys, David Nilson, *Roanoke*
Kiernan, David John, *Arlington*
King, James P Jr, *Galax*
Klein, Andrew Mark, *Richmond*
Kornblut, Alan David, *McLean*
Kreisler, Leslie S, *Richmond*
Lambert, Paul R, *Charlottesville*
Lawande, R L, *Manassas*
Levine, Jack L, *Falls Church*
Levine, Paul A, *Charlottesville*
Little, Scott W, *Roanoke*
Lyle, John P, *Suffolk*
Mahat, V Patrick, *Vienna*
Manwaring, John L, *Warrenton*
March, Lois Rae, *Richlands*
Marion, Edward David, *Falls Church*
Mashburn, Mark Allen, *Reston*
Massey, Caleb R III, *Falmouth*
Mayes, Kenneth L, *Portsmouth*
Mc Daniels, L B, *Newport News*
Mc Lean, Walter C, *Charlottesville*
Meadema, Samuel J, *Danville*
Meeks, Thomas George, *Richmond*
Mendez, Prudencio, *Virginia Beach*
Meredith, George Minor II, *Norfolk*
Middleton, Paul Jr, *Richmond*
Mihalyka, Eugene E, *Cheriton*
Miller, George Francis, *Alexandria*
Mirmelstein, Alvin B, *Newport News*
Moghtader, Ali, *Woodbridge*
Montague, John W, *Richmond*
Moon, Cary Nelson Jr, *Charlottesville*
Moore, George Robert, *Winchester*
Mrzljak, Vesna, *Alexandria*
Murden, Ernest Aubrey Jr, *Portsmouth*
Nassif, Ramzy I, *Cedar Bluff*
Nathan, Michael Jay, *Alexandria*
Neal, Roger Dale, *Abingdon*
Neas, Gregory Alan, *Clifton*
Newbill, E Thomas, *Richmond*
Nicholson, Charles T Jr, *Tappahannock*
Nicklay, James Thomas, *Falls Church*
Niechniedowicz, Lynne Marie, *Woodbridge*
Okail, Kamal K, *Alexandria*
Oppenheim, Joshua P, *Falls Church*
Overcash, Kelly Ennis, *Danville*
Pappous, Panagiotis, *Springfield*
Pastore, Peter N, *Richmond*
Perini, Clinton J, *Petersburg*
Pharr, Scott Yorke III, *Williamsburg*
Pholeric, John F Jr, *Arlington*
Pifer, William H, *Winchester*
Powell, Jeffrey P, *Chesapeake*
Prass, Richard L, *Norfolk*
Pumphrey, Robert Earl Jr, *McLean*
Quick, Cedric Albert, *McLean*
Ralph, Robert D, *Falls Church*
Redmon, Robert Bruce, *Culpeper*
Renick, Ole Wibholm, *Roanoke*
Risher, John Calhoun, *Lynchburg*
Robins, Richard Bailey, *Newport News*
Rol, Cornelis, *Danville*
Roper, Albert L, *Norfolk*
Sabri, Joseph A, *Arlington*
Safavian, Morteza S, *Fairfax Station*
Salasky, Milton, *Norfolk*
Schechter, Gary Lee, *Norfolk*
Scheidemandel, Heinz H E, *Annandale*
Scher, Richard Lyle, *Charlottesville*
Sellers, John G, *Norfolk*
Selman, John William, *Martinsville*
Shaia, Fred Thomas, *Richmond*
Sharma, Gopesh K, *Fairfax*
Shim, Jaimoon M, *Hopewell*
Sibay, Mounzer F, *Arlington*
Silver, Steven M, *Roanoke*
Sismanis, Aristides, *Richmond*
Sly, Donald Eugene, *Norfolk*
Smith, George Henry Jr, *Winchester*
Smith, Maynard Putney, *Richmond*
Smith, William H Jr, *Hampton*
Soltany, Ray A, *Mc Lean*
Spagnoli, Scott David, *Arlington*
Sprinkle, Philip Martin, *Martinsville*
Steffey, William Rue, *Newport News*
Stehlik, John Mc Teer, *Virginia Beach*
Strausbaugh, Paul L, *Clifton Forge*
Suma, Ben P, *Petersburg*
Sydnor, J Brantley, *Roanoke*
Sydnor, Thomas Austin Jr, *Charlottesville*
Teachey, William Swain, *Virginia Beach*
Thompson, Edward G, *Winchester*
Thomson, David Kevin Robb, *Charlottesville*
Thrift, George N, *Richmond*
Villafuerte, Cesar Ferolin, *Richmond*
Wade, James Meron, *Abingdon*
Wadley, John Kenneth, *Manassas*
Wallenborn, Peter A Jr, *Roanoke*
Wallenborn, White M, *Charlottesville*
Weaver, Delmar F, *Culpeper*
Weis, Richard Charles, *Waynesboro*
Wilkes, William Lee, *Richmond*
Williams, George H, *Richmond*
Williams, Rodney William, *Arlington*
Yenson, Anthony Cecil, *Arlington*
Zaluzec, Daniel J, *Fredericksburg*
Zapanta, Conrado R, *Harrisonburg*

Pediatric Allergy

Bundy, Walter E Jr, *Richmond*
Davis, Harvey Daniel, *Virginia Beach*
Inglefield, Joseph Thacher, *McLean*
Latkin, Peter Charles, *Falls Church*
Miller, Abbe L, *Vienna*
Mollen, Edward Leigh, *Richmond*
Pinkerton, Herman H Jr, *Abingdon*
Walton, David Clark, *Roanoke*

Pediatric Cardiology

Bullaboy, Charles A, *Norfolk*
Jennings, Rufus B Jr, *Norfolk*
Lin, Hsing-Wu, *Chester*
Mauck, Henry P Jr, *Richmond*
Moskowitz, William Bernard, *Richmond*
Rheuban, Karen S, *Charlottesville*
Robertson, Louise W, *Richmond*
Schieken, Richard M, *Richmond*

Pediatric Surgery

Coulson, John Dana, *Norfolk*
Debari, Anthony, *Charlottesville*
Hepner, Seymour I, *Annandale*
Hodin, Earl, *Annandale*
Nuss, Donald Jr, *Norfolk*
Rodgers, Bradley M, *Charlottesville*
Walburgh, Carl Eric, *Norfolk*

Pediatrics

Aaronson, Allen E, *Fredericksburg*
Abbassi, Valiollah, *McLean*
Abdalla, Wagida A, *McLean*
Abernathy, Ted R, *Midlothian*
Acquavella, Anthony Peter, *Mechanicsville*
Adams, Cheryl Teres, *Roanoke*
Adler, Stuart P, *Richmond*
Ahmad, Razia Sultana, *Bluefield*
Ainsworth, Deborah Lowry, *Norfolk*
Akbar, Jamal Uddin, *Virginia Beach*
Albert, Moses Abey, *Midlothian*
Albertson, Thomas Howard, *Lynchburg*
Aldea, Erlinda Doncello, *Covington*
Allen, Robert W Jr, *Troutville*
Althouse, Douglas Glenn, *Roanoke*
Altieri, Michael F, *McLean*
Alvarado, Maritza, *Norfolk*
Alvarado-Echeverria, Marcio A, *Alexandria*
Amin, Bipinchandra G, *Fairfax*
Amin, Jyoti S, *Alexandria*
Amin, Sanjay M, *Norfolk*
Anderson, Carolyn Faye, *Alexandria*
Anderson, Robert Harper, *Alexandria*
Andrako, John David, *Richmond*
Andrew, Lori Rothstein, *Leesburg*
Andrews, Jack P, *Richmond*
Anez, Yasmin Khidou, *Vienna*
Ang, Choyan Lee, *Newport News*
Archuleta, Bobby A, *Richmond*
Arkin, David L, *Richmond*
Arline, James S, *Chesapeake*
Armstrong, Lorraine June, *Charlottesville*
Arnold, Gayle G, *Richmond*
Arnold, John Byrd, *Lynchburg*
Arnoldson, Jorge Jr, *Burke*
Arrieta, Mary Cathrine, *Colonial Heights*
Atkin, Joan Fay, *Charlottesville*
Auld, Richard Mcguire, *Covesville*
Ault, Wendy C, *Manassas*
Austin, Harry Paul, *Charlottesville*
Austin, Leonard Anthony, *Richmond*
Awrich, Paula D, *Richmond*
Bachman, Kay D, *Falls Church*
Bailey, George W, *Alexandria*
Baker, Frances W, *Norfolk*
Bakht, Sufia Begum, *Portsmouth*
Balasubramaniam, Meenakshsundaram, *Big Stone Gap*
Ball, Achana Vimuktalaba, *Alexandria*
Balsamo, Pat A, *Burke*
Bandyopadhyay, Utpala Mukherji, *Newport News*
Barnhart, Ruth, *Roanoke*
Barot, Lydia M, *Alexandria*
Barr, Robert W, *Falls Church*
Barringer, Michel Laron, *Richmond*
Barsanti, Ardwin H, *Annandale*
Barsanti, Ronald G, *Vienna*
Bason, William M, *Norfolk*
Bass, William Thomas, *Norfolk*
Bautista, Divinia Maliwat, *Forest*
Bawa, Balraj, *Lynchburg*
Bayes, Beverley J, *Falls Church*
Beale, Jefferson D Jr, *Danville*
Beaven, Charles W, *Norfolk*
Beazley, Luthur A III, *Salem*
Begley, Charles Jeffrey, *Norton*
Bekenstein, William Leon, *Fairfax*
Bell, Sandra Anderson, *Richmond*
Benjamin, John T, *Charlottesville*
Bennett, L P Robinson, *Richmond*
Bergman, Gary J, *Alexandria*
Berman, Larry William, *Norfolk*
Berman, Wallace F, *Richmond*
Bernstein, Susan Ellen, *Springfield*
Berrey, Bedford H, *Midlothian*
Bevan, Herbert Everett III, *Chesapeake*
Bingol, Mehmet M, *Hampton*
Bisese, Albert Joseph, *Norfolk*
Bitar, John George, *Alexandria*
Black, Susan Harriet, *Fairfax*
Blake, Jeffrey D, *Alexandria*
Blakey, Peter P, *Midlothian*
Blasco, Peter A, *Charlottesville*
Blizzard, Robert M, *Charlottesville*
Boatwright, Joseph W III, *Richmond*
Boggess, H Preston, *Roanoke*
Boisseau, Sandra L, *Richmond*
Bolduc, Stephen Patrick, *Newport News*
Bondareff, Erwin Allen, *Alexandria*
Bones, Joseph Thomas, *Richmond*
Booker, Armistead P, *Charlottesville*
Boone, Carolyn Jean, *Richmond*
Booth, O Watts, *Newport News*
Boozer, Jefferess Hannings, *Charlottesville*
Borowitz, Stephen Mark, *Charlottesville*
Bott, D Gregory, *Winchester*
Bowles, Paul Elwood, *Roanoke*
Bowser, Barrington H, *Richmond*
Boyd, William E, *Norfolk*
Boyd, William Everett Jr, *Low Moor*
Boyle, Robert John, *Charlottesville*
Bregman, Robert L, *Alexandria*
Brenn, Bruce Randall, *Richmond*
Brennan, James F Jr, *Mechanicsville*
Brennan, Teresa Lynch, *Charlottesville*
Bright, George Meredith, *Richmond*
Brookman, Richard Robert, *Richmond*
Bruch, William M, *Richmond*
Bryant, Stephen Robert, *Lynchburg*
Bunce, John D, *Annandale*
Burch, Charles D III, *Richmond*
Burke, Robert Thomas, *Hampton*
Burn, John F, *Front Royal*
Burns, James E, *Ruckersville*
Burt, Leslie Stephen, *Harrisonburg*
Burtner, L D, *Harrisonburg*
Burwell, Carolyn Smith, *Franklin*
Busch, Joyce Marie, *Petersburg*
Butler, Lilia G, *Alexandria*
Byrd, Ann Carol, *Richmond*
Byrd, Robert Stacy, *Blacksburg*
Cader, Azad M, *Richmond*
Cader, Josephine B, *Richmond*
Calcagno, Philip L, *McLean*
Caldroney, Thomas W, *Newport News*
Caldwell, Eston Robert III, *Winchester*
Campbell, Corder Compton, *Fairfax*
Campbell, Ruth F Williams, *Richmond*
Carpenter, Martha A, *Charlottesville*
Carr, William M, *Manassas*
Casey, Catherine Sue, *Arlington*
Cassell, Stuart Kent Jr, *Blacksburg*
Cassidy, William Michael, *Vienna*
Castello, Fred M, *Waynesboro*
Castro, Emmanuel F, *Falmouth*
Cerreto, Madge Zacharias, *Richmond*
Cha, Young S Pyun, *Annandale*
Chalkley, Thomas Spencer, *Richmond*
Chan, James Chiu, *Richmond*
Chan, Yuk-Keng D, *Richmond*
Chandra, Renu, *Alexandria*
Chang, Chia Tzuo, *Petersburg*
Chapin, William Evans, *Callands*
Charity, Cynthia M, *Richmond*
Chaten, Frank Christopher, *Richmond*
Chaten, Joanne Hammer, *Richmond*
Chen, Mei-Ling Wu, *Fairfax*
Chevalier, Robert L, *Charlottesville*
Chhabra, Yuskiran Kaur, *Fairfax Station*
Childress, James M, *Fredericksburg*
Cho, Young H, *McLean*
Choi, Koo Young, *Hampton*
Christie, Catherine Michele, *Charlottesville*
Christoph, Richard Allen, *Charlottesville*
Chun, Edward Yong-Kwon, *Bluefield*
Chusuei, Oraphan Chomthongdi, *McLean*
Chusuei, Richard V, *McLean*
Cicero, Michael Anthony, *Franklin*
Cioletti, Roy Robert, *Manassas*
Clapp, Deborah G, *Arlington*
Clarke, Tiffany Lee, *Arlington*
Clarke, William L, *Charlottesville*
Cobb, Audrey Denise, *Woodbridge*
Cockerham, Elaine L, *Springfield*
Cockrell, Janice L, *Richmond*
Colley, Amelia Holder, *Richmond*
Collins, Gretchen Lange, *Alexandria*
Comer, F Edward, *Harrisonburg*
Conner, Alvin Eugene, *Manassas*

Pediatrics *(cont'd)*

Connor, Hilary Herbert, *Richmond*
Conrad, Debra Dee, *Charlottesville*
Cook, Sarah, *Amelia*
Cook, William Henry Jr, *Radford*
Coren, Sidney W, *Virginia Beach*
Cox, Harry Duffield, *Portsmouth*
Craft, William Hugh, *Roanoke*
Craig, Seth Clayton III, *Fredericksburg*
Crock, Thomas Rankin, *Falls Church*
Crowder, Thomas Harold Jr, *South Boston*
Curd, Lewis Howard Jr, *Williamsburg*
Curry, Richard L, *Suffolk*
Curry, William Lake, *Richmond*
Cypress, George C Jr, *Hampton*
D'Alessandro, Gloria G, *Charlottesville*
Daley, Timothy Horton, *Arlington*
Dammann, John Francis Jr, *Charlottesville*
Damron, Joseph M, *Winchester*
Darnall, Robert A, *Charlottesville*
Daugherty, Elizabeth C, *Fairfax*
Davidow, Daniel Nelson, *Richmond*
Davis, Beth Ellen, *Charlottesville*
Davis, Edward Garland Jr, *Richmond*
Davis, John E, *Richlands*
Davitt, Mary Catherine, *Arlington*
Davoli, Enrico, *McLean*
Day, Sarah E, *Richmond*
Decker, Elisabeth B, *Lovettsville*
Dedman, Elizabeth Bohon, *Blacksburg*
De La Burde, Brigitte E, *Petersburg*
De La Cruz, Gloria V, *Portsmouth*
Demetrakopoulos, George Ev, *Falls Church*
Demuth, Susan A, *McLean*
Dengel, Gisela A, *Front Royal*
Depaola, Frank, *Vienna*
Desai, Varsha J, *Roanoke*
De Triquet, John Michael, *Chesapeake*
Devitt, Susan Strange, *Virginia Beach*
De Witt, Gerald Wallace, *Newport News*
Dewitte, David Bruce, *Virginia Beach*
Dexters, Yvonne L, *Portsmouth*
Dhru, Aruna D, *Chester*
Diaz, Adolfo Leon, *Arlington*
Dickens, Michael Douglas, *Charlottesville*
Dilks, Susan Anderson, *Charlottesville*
Dionisio, Teresita C, *Farmville*
Dipaola, Anthony, *Reston*
Dixon, David Lloyd III, *Roanoke*
Dizon, Pilar C, *Virginia Beach*
Dockery, W Keith, *Roanoke*
Doctor-Jose, Nora, *Alexandria*
Donowitz, Leigh G, *Charlottesville*
Doron, Isaac G, *Suffolk*
Doupnik, Ladislav, *Richlands*
Draper, David Adrian, *Richmond*
Drewry, David B, *Petersburg*
Duckwall, Francis Joseph, *Salem*
Duff, Pamela B, *Louisa*
Duffee, James Harvey, *Greenwood*
Dunn, Nancy L, *Richmond*
Dunston, Frances Johnson, *Richmond*
Dwyer, James Henry, *Richmond*
Dyar, Kathryn W, *Grafton*
Dziatkiewicz, Jowita, *Chesapeake*
Ebaugh, Duane Wallace, *Virginia Beach*
Ellini, Ahmad, *Burke*
Ellwood, Leslie Clive, *McLean*
Engel, John Joseph, *Martinsville*
Eron, Lawrence J, *Annandale*
Eslami, Frank F, *Burke*
Estrera, Leonor Otadoy, *Chesapeake*
Etheridge, James E Jr, *Norfolk*
Evans, Geoffrey Stuart, *Fairfax*
Everett, Joel Campbell, *Richmond*
Everett, William C Jr, *Newport News*
Evers, Joseph Charles, *McLean*
Fajardo, Jesus Eduardo, *Portsmouth*
Falterman, Casey G, *Richmond*
Familant, Joseph W, *Hampton*
Fandino, Ernesto, *Sterling*
Farber, Herman Wilson, *Petersburg*
Farber, Jon Matthew, *Alexandria*
Farrell, John David, *Reston*
Farrell, Walter John Jr, *McLean*
Farzaneh, Iraj, *Alexandria*
Felberbaum-Schuster, Donna, *Herndon*
Feldman, William Edward, *Norfolk*
Feriozi, Dante J, *Arlington*
Fidler, Robert Y, *Richmond*
Fildes, Robert Duane, *Vienna*
Finch, Albert Bates, *Norfolk*
Fink, Frederic Neil, *Norfolk*
Fink, H William, *Norfolk*
Fink, Robert Alan, *Norfolk*
Flack, Thelma Apiado, *Burke*
Fletcher, John Stevenson, *Williamsburg*
Folston, M James, *Broadway*
Forbes, Dawn Elizabeth, *Roanoke*
Ford, Deborah Kathleen, *Chesapeake*
Ford, Raymond F, *Charlottesville*
Foreman, John William, *Richmond*
Forman, Martin Seth, *Reston*
Fraga, Juan R, *Alexandria*
French, John D, *Martinsville*
Fried, William A, *Alexandria*
Friehling, Linda Ann, *Alexandria*
Funkhouser, Laura Susan, *Charlottesville*
Gallagher, Walter J, *Alexandria*
Gallanosa, Mayorico Gamit Jr, *Danville*
Garcia, Luis Armando, *Richlands*
Gargus, Regina Ann, *Manassas*
Garner, Fredric Bruce, *Burke*
Garrison, Bobby, *Norfolk*
Gewanter, Harry L, *Richmond*
Giancola, Frank James, *Centreville*
Giannuzzi, Vito A, *Alexandria*
Gibney, Sheila Schlunt, *McLean*
Gibson, Noah Francis, *Danville*
Gilbert, Walter L, *Virginia Beach*
Gillerman, Richard Gordon, *Norfolk*
Glick, Aaron, *Alexandria*
Glikin, Sanford Elliot, *Alexandria*
Goatcher, Rheta Horton, *Glen Allen*
Goldberg, Constance L, *Great Falls*
Goldblatt, Seymour Zonald, *Alexandria*
Goldenberg, Robin Ira, *Annandale*
Goldman, William D, *Arlington*
Gollub, Samuel W, *Virginia Beach*
Gomez, Maximino, *Petersburg*
Gomez, Robert James, *Norfolk*
Gomez, Roberto Ariel, *Charlottesville*
Gomez, Roy Clement, *Richlands*
Gondhalekar, Smita Shridhar, *Fairfax*
Gonzales, Patricia D, *Hopewell*
Gordge, William Noel, *Roanoke*
Gordon, Edward I, *Farmville*
Gower, Arthur G, *Manassas*
Graham, Martin Frank, *Richmond*
Graham, Maurice Edward, *Williamsburg*
Gray, Nelson Turner, *Virginia Beach*
Gregory, Douglas Blair, *Portsmouth*
Grizzard, John Dallas, *Midlothian*
Guilfoyle, Francis M, *Roanoke*
Gulmatico, Oscar B, *South Hill*
Gunnoe, Eric Lee, *Norton*
Gunther, Robert Carl, *Waynesboro*
Gutcher, Gary Robert, *Richmond*
Gutgesell, Howard Philip Jr, *Charlottesville*
Gutgesell, Margaret Evans, *Charlottesville*
Gutierrez, Fe Mendiola, *McLean*
Haas, Richard J, *Richmond*
Hakmeh, Nazir, *Grundy*
Hall, Glenn Claire Jr, *Radford*
Hamilton, Kathleen Marie, *Fairfax*
Hancock, Edward H Jr, *Lynchburg*
Handal, Neyib J, *Petersburg*
Hanzel, Jeffrey Sheldon, *Richmond*
Hardman, George White Jr, *McLean*
Harman, W E, *Staunton*
Harper, Edwin A, *Lynchburg*
Harrison, Mary Ellett, *Newport News*
Hart, Kirby Thompson Jr, *Petersburg*
Hasell, Rhett Hagood, *Virginia Beach*
Hawkes, David Lee, *Charlottesville*
Hayden, Gregory F, *Charlottesville*
Hayes, James W, *Norfolk*
Hazra, Meena, *Richmond*
Heller, Tania, *Springfield*
Henderson, Ellen Louise, *Richmond*
Henderson, William W IV, *Danville*
Hendley, Joseph Owen, *Charlottesville*
Heppel, David Elliott, *Reston*
Herman, Bernard D, *Richmond*
Heymann, Peter W, *Charlottesville*
Hickam, George Lindsay, *Roanoke*
Hill, Eurica Semon, *Richmond*
Hill, Kathryn Dodds, *Virginia Beach*
Hock, Randy Alan, *Charlottesville*
Hoegerman, Georgeanne, *Newport News*
Hoffler, Eric Wyckliffe, *Richmond*
Hoffman, Robert Arnold, *Richmond*
Hogan, Martha Lou, *Springfield*
Hogg, John Roger, *Newport News*
Hogg, Paul, *Gloucester Point*
Hooker, Timothy H, *Danville*
Hope, Phyllis Rhian, *Norfolk*
Hostler, Sharon Lee, *Charlottesville*
Houck, Peter William, *Lynchburg*
Hubbard, Thomas W, *Norfolk*
Hudgens, Robert Oscar, *Richmond*
Huff, Dawn Maree, *Richmond*
Hughes, Charles B, *Wytheville*
Hughes, Marjorie Helgans, *Arlington*
Hull, Tom Allen, *Woodbridge*
Humphries, Thomas J, *Salem*
Hunt, Robert Clarence, *Falls Church*
Huntington, Daniele F, *Falls Church*
Huntley, Carolyn Joanne, *Norfolk*
Hylton, Paul Hampton Jr, *Winchester*
Imburg, Jerome, *Alexandria*
Ingram, Virginia G, *Fairfax*
Iranyi, Magdolna A, *Alexandria*

Pediatrics *(cont'd)*

Ismail, Muhammad S, *Richmond*
Jacob, Annamma John, *Arlington*
Jacobs, William M, *Roanoke*
Jaffe, Michael, *Richmond*
Jain, Sureshchand D, *Wise*
Janko, Anita Rebecca, *Alexandria*
Jason, Casey John, *Alexandria*
Javedan, Mehrdad, *McLean*
Jefferies, Allan H, *Norfolk*
Jeffries, Margaret Nichols, *Warrenton*
John, Sarah A, *Falls Church*
Johnson, David H, *Norfolk*
Johnson, Ray Monroe, *Vienna*
Johnson, Robert A, *Virginia Beach*
Johnston, William Burton, *Richmond*
Jones, Davis Benton III, *Norfolk*
Jones, George Frederick, *Marion*
Jones, John P, *Hanover*
Jones, Pamela Kramish, *Richmond*
Jones, Raymond J, *Fredericksburg*
Jones, Stuart P Jr, *Winchester*
Jose, Nora D, *Alexandria*
Josef-Guanzon, Patrocinio Cruz, *Danville*
Joyce, Michael Harrison, *Norfolk*
Ju, Wook Ja Lee, *Virginia Beach*
Jurs, Dennis Gregg, *Abingdon*
Kagan, Harvey Jay, *Norfolk*
Kagey, William Joseph, *Salem*
Kahler, Barbara Lyons, *Tappahannock*
Kaplowitz, Paul Bernard, *Richmond*
Kappes, William C Jr, *Waynesboro*
Karotkin, Edward H, *Norfolk*
Karp, Glenda S, *Virginia Beach*
Kastner, Lee Norman, *Portsmouth*
Kattwinkel, John, *Charlottesville*
Kauder, Bruce M, *Tabb*
Kauff, Richard Eden, *Kilmarnock*
Kaufman, Paul, *Arlington*
Kaw, Nellie Ong, *Leesburg*
Kearney, Edward F, *White Marsh*
Keeley, Joseph John, *Chesepeake*
Keeve, Jack Philip, *Alexandria*
Keim, Daniel Edward, *Burke*
Keiter, Mary Beth, *Chesapeake*
Keller, Stephen Richard, *Falls Church*
Kellett, Gordon Neil II, *Midlothian*
Kelley, Kathleen R, *Reston*
Kelly, John Francis, *Alexandria*
Kelly, Lawrence F, *Reston*
Kelly, Thaddeus E, *Charlottesville*
Kendig, Edwin L Jr, *Richmond*
Kerkering, Kathryn W, *Richmond*
Kern, Marguerite Ann, *Montpelier*
Kernitsky, Lydia, *Midlothian*
Kesler, Richard W, *Charlottesville*
Kevorkian, Constance Morton, *Virginia Beach*
Khakee, Shamshuddin G, *Newport News*
Khan, Ghazala Yasmin, *Virginia Beach*
Khan, Jamil Hakim, *Norfolk*
Khanna, Urmilla, *Fairfax*
Kheirbek, Mahmoud, *Arlington*
Kiernan, Sharon Coyle, *Alexandria*
Kilby, Walter B, *Culpeper*
Kilby, William Irvin, *Harrisonburg*
Kilpatrick, Kathryn Ann, *Arlington*
Kim, Chin Moon, *Woodbridge*
Kim, Jong Won, *Lynchburg*
Kim, Sung Yong, *Portsmouth*
King, Audrey Cox, *Richmond*
King, Kenneth R, *Tabb*
Kinnebrew, Peter Siler, *Richlands*
Kirkpatrick, Barry V, *Richmond*
Klam, Warren Peter, *Falls Church*
Kluge, Robert Carter, *Staunton*
Knerr, Robert James, *Vienna*
Knox, Cecil Bryon III, *Salem*
Knox, Henry Donald, *Springfield*
Koch, William Calvin, *Richmond*
Koehl, George William, *Norfolk*
Koppanyi, Zsolt Huba Bulcsu, *Richmond*
Koziol, Dennis Frank, *Virginia Beach*
Kraft, Colleen Anne, *Mechanicsville*
Kramer, Lloyd Irvin, *Falls Church*
Krebs, Gary L, *Richmond*
Krell, Linda Sue, *Roanoke*
Krenytzky, Stephen Marc, *Manassas*
Kruger, Karen J, *Richmond*
Kulczycki, Lucas L, *Arlington*
Kumar, Krishnan Sivasankara, *Woodbridge*
Kunkle, Arthur Alfred III, *Roanoke*
Kuperminc, Denise S, *Richmond*
Kwun, Doo-Yung, *Tazewell*
Lafave, John Bradley, *Martinsville*
Lamberson, Robert Laurence, *Williamsburg*
Lambert, Lynn D, *Harrisonburg*
Larkin, Sylvia Macedo, *Alexandria*
Lassiter, Max Errington, *Danville*
Latif, Razia, *Alexandria*
Lauzon, John David, *Hampton*
Leach, Edwin Morse, *Williamsburg*
Lebita-Ceballos, Victoria M, *Marion*
Lechaux, Pierre A, *Alexandria*
Lee, Margaret C, *Falls Church*
Lee, Ming-Shoei, *Hopewell*
Lee, Richard Mimms, *Ashland*
Lee, Soo Hwa, *Suffolk*
Lee, Sue Hollowell, *Chesapeake*
Leichtman, Lawrence Gene, *Norfolk*
Lenn, Nicholas J, *Charlottesville*
Leslie, Ann Debra, *Norfolk*
Leverty, Alexander P II, *Richmond*
Levien, Michael G, *Charlottesville*
Levy, Micheline Sarah, *Alexandria*
Libby, Russell C, *Fairfax*
Lien, Buu That, *Norfolk*
Liner, Steven R, *Newport News*
Lingaraju, Sathyavathi, *Richmond*
Link, Kathleen M, *Annandale*
Lischwe, Catherine A, *Arlington*
Litman-Mazo, Fern R, *Falls Church*
Littleton, Philip Ray, *Springfield*
Llaneras, Rene Fernando, *Fairfax*
Loganathan, Sri Tharan, *Richmond*
Lohr, Jacob Andrew, *Charlottesville*
Lopresti, Joseph M, *Fairfax Station*
Lorenz, Richard Lawrence, *Woodbridge*
Lovinger, Robert D, *Richmond*
Lowell, William Grayson, *Chesapeake*
Lucking, Steven Eric, *Midlothian*
Luke, Mary Jane, *Covington*
Lum, Natalie Inge, *Petersburg*
Lurie, Marc Alan, *Springfield*
Lutz, Roy Winston, *Winchester*
Lynch, Ellen Mary, *Reston*
Machen, Charles William, *Charlottesville*
Macyko, Catherine Anne, *Chesapeake*
Maganias, Nicholas H, *Reston*
Magnant, George Arthur, *Alexandria*
Magnant, George J, *Falls Church*
Mahoney, Rhoda L Bland, *Richmond*
Malcolm, Bradley S, *Lynchburg*
Malliet, Jennifer L, *Richmond*
Mancuso, Frank Smith, *Portsmouth*
Mann, Ruth Avigan, *Fairfax*
Maphis, Frederick D Jr, *Wise*
Mardini, Mohamad K, *McLean*
Marsland, David Wilson, *Richmond*
Martin, David Craig, *Warrenton*
Martin, Edward D, *Arlington*
Martin, Robert E, *Arlington*
Mascarinas, Thelma C, *Virginia Beach*
Mason, Marsha A, *Manassas*
Massaro, Thomas Andrew, *Charlottesville*
Massey, Gita Vasers, *Richmond*
Massie, Jean Marie, *Arlington*
Mastrota, Francis M, *Falls Church*
Maurer, Harold Maurice, *Richmond*
May, Dean Francis, *Alexandria*
May, Linda Gale, *Richmond*
May, William H, *Virginia Beach*
Mayer, Alden B, *Richmond*
Mc Andrews, Julie Sanfilippo, *Woodbridge*
Mc Aveney, William J, *Springfield*
Mc Carron, Patricia Ann, *Pulaski*
Mc Clintock, William Morris, *Springfield*
Mc Connaughey, John S, *Chatham*
Mc Cue, Frank A, *Abingdon*
Mc Daniel, Nancy Lee, *Charlottesville*
Mc Donald, Robert M, *Harrisonburg*
Mc Donald, Ruth Isabel, *Reston*
Mc Donald, Thomas D, *Grundy*
Mc Dowall, James Douglas, *Fairfax*
Mc Dowell, Alice Williams, *Marion*
Mc Elfish, Karen Roberts, *Arlington*
Mc Gee, Cheryl A, *Reston*
Mc Ghee, Judith F, *Midlothian*
Mc Gorry, Thomas Patrick, *Sterling*
Mc Govern, John Joseph, *Leesburg*
Mc Guire, John Patrick, *Arlington*
Mc Kee, Thistle M, *Alexandria*
Mc Kinney, Jennifer L, *Springfield*
Mc Phee, Hugh T, *Norfolk*
Mc Pherson, Elizabeth Wright, *Reston*
Mc Williams, Nancy Brenda, *Richmond*
Megson, Mary Hodges, *Richmond*
Melez, Kathleen Anne, *Annandale*
Meloy, Linda Dianne, *Richmond*
Meltzer, Richard S, *Leesburg*
Menon, Padman Achutha, *Virginia Beach*
Meredith, Elizabeth H, *Norfolk*
Mesrobian, Robert Bennett, *Falls Church*
Metzger, Arthur Zelig, *McLean*
Meyer, Harry Martin Jr, *Waterford*
Meyer, Marilyn A, *Richmond*
Meyer, Michael B, *Roanoke*
Mickell, John J, *Richmond*
Mika, Katherine Dalton, *Culpeper*
Milanovich, Robert Anthony, *Lynchburg*
Miles, Robert Milton, *Lynchburg*
Miller, Karen J, *Reston*
Miller, William W, *Richmond*

Pediatrics *(cont'd)*

Mills, Julia H, *Midlothian*
Min, Frances W, *McLean*
Mink, James W, *Virginia Beach*
Mistr, Ernest Noel, *Abingdon*
Mitchell, Joe E, *Bristol*
Mitchell, John Wayne Jr, *Manassas*
Mohapi, Edith Q, *Annandale*
Mohrmann, Margaret Elizabeth, *Charlottesville*
Moinfar, Mohamad Reza, *Fairfax*
Molina, Carmen A, *Norfolk*
Moniz, Albert, *Falls Church*
Monteleone, Philip Michael, *Richmond*
Montero, Raul E, *Marion*
Montes, Jorge Eduardo, *Norfolk*
Moon, Young Sun, *Alexandria*
Moore, Frederic P II, *Richmond*
Moore, Mary Ellen, *Richmond*
Moore, Richard Henning, *Lexington*
Morehouse, Nancy Wetzel, *Radford*
Morelos, Rodolfo Magdato, *Marion*
Morgan, James L, *Portsmouth*
Morris, Richard C, *Lynchburg*
Morris, Thomas Ellsworth, *Newport News*
Morton, Richard William, *Charlottesville*
Mosby, Robert Thomas Jr, *Virginia Beach*
Motley, Vickie C, *Newport News*
Moyer, Donna Browder, *Springfield*
Mraz, Royann C, *Newport News*
Mueller, Dawn Grigg, *Richmond*
Mulreany, Patricia Diane, *Richmond*
Mumper, Elizabeth A, *Lynchburg*
Murias, Juan Suarez, *Springfield*
Murphy, Laurence J, *Burke*
Murphy, William F Jr, *Norfolk*
Murray, John A, *Franklin*
Murthy, Gurunanjappa Siddappa, *Petersburg*
Myer, Edwin Charles, *Richmond*
Myers, Lynne Beth, *Falls Church*
Nabavi, Mehdi, *Alexandria*
Nachajski, Peter John, *Alexandria*
Nagle, David Ray, *Arlington*
Napolitano, Michael August, *Danville*
Nard, Jeffrey Howard, *Virginia Beach*
Nassif, Sami I, *Cedar Bluff*
Navarro, Ramon G Jr, *Chesapeake*
Nayak, Sindhu R, *Virginia Beach*
Neikirk, William I, *Charlottesville*
Nelson, Stephen Craig, *Portsmouth*
Nelson, William Brittain, *Norfolk*
Nestor, John O, *Arlington*
Nguyen, Tung Duc, *Falls Church*
Nicholas, David Dunston, *Oakton*
Nieves-Rivera, Francisco, *Charlottesville*
Nobarian, Rayeheh A, *McLean*
Noble, Robert Earl, *Richmond*
Nofsinger, Dennis E, *Midlothian*
Norris, David M, *Norfolk*
O'Connor, Dennis M, *Fairfax*
Ogburn, John F III, *Blacksburg*
Orlosky, Albert J, *Arlington*
Ossofsky, Helen Johns, *McLean*
Oswald, Leticia Khu, *McLean*
Overman, Ilma Meade, *Fredericksburg*
Overton, Thomas Pairo, *Richmond*
Ownby, Ralph Jr, *Richmond*
Owrutzky, Michele Enid, *Falls Church*
Page, Maysville J Owens, *Richmond*
Painter, John W, *Fredericksburg*
Palat, Meera Koyappalli, *Chesapeake*
Panich, Banyat, *South Boston*
Panizales, Elma G, *Woodbridge*
Papailias, Efthalia L, *Arlington*
Paraguya, Maria, *Fairfax*
Parente, Kathleen O'Neil, *Alexandria*
Park, Tong S, *Falls Church*
Parr, Emily Luscher, *Richmond*
Pasquariello, Peter J, *Carrollton*
Patel, Binita Dilip, *Cedar Bluff*
Patel, Rajnikant R, *Grundy*
Patel, Usha T, *Virginia Beach*
Pathak, Arvind Kumar, *Reston*
Patton, Leo Richard, *Woodbridge*
Paulsen, Elsa Proehl, *Charlottesville*
Payne, Catherine Louise, *Galax*
Payne, Robert Kenneth, *Galax*
Payne, Thomas William, *Newport News*
Peacock, John H Jr, *Arlington*
Pearl, Elliott R, *Charlottesville*
Pears, Jenifer Chaffee, *Richmond*
Peck, Dawn Hughes, *Lexington*
Perdue, Judith Sirotta, *Harrisonburg*
Perriello, Vito A Jr, *Charlottesville*
Peters, Earl R, *Virginia Beach*
Peterson, Wesley Harold, *Winchester*
Pfeffer, Bruce William, *Springfield*
Phillips, Frederic Alden, *Fredericksburg*
Pierce, Douglas E, *Roanoke*
Pillsbury, Susan Lewis, *Richmond*
Pincus, Lawrence Graff, *Arlington*
Pinkston, J Elizabeth, *Nassawadox*
Pliska, John Edward, *Richmond*
Plumb, Deborah Jean, *Norfolk*
Polanshek, Mark Mumford, *Richmond*
Poley, J Rainer, *Norfolk*
Ponce, Pamela Ann, *Virginia Beach*
Popish, Paul William, *Hampton*
Portal, Cynthia Thrush, *Falls Church*
Porter, Frederick S Jr, *Norfolk*
Powell, Beverly A, *Arlington*
Powell, Drusilla Saunders, *Chesapeake*
Powell, John Gary, *Lynchburg*
Prescott, Georgia Ann, *Williamsburg*
Pressman, Howard I, *McLean*
Preston, Ellen K, *Richmond*
Pretlow, Robert Ashton III, *Poquoson*
Price, Frank Wilson, *Lexington*
Price, Walter S, *Hampton*
Price, Weldon A, *McLean*
Privitera, Christine M, *Mechanicsville*
Puglise, Joseph V, *Lorton*
Pujol, Jackie, *Vienna*
Queen, Jeffrey Scott, *Charlottesville*
Radcliffe, Jessica Jane, *Richmond*
Ragavan, Nilima Manudhane, *McLean*
Rahal, Frederick, *Richmond*
Rahman, Wassam Mohammed, *Falls Church*
Rajaram, Suryakumar, *Yorktown*
Rajurkar, Madhusudan Govind, *Virginia Beach*
Rak, Ihor Wolodymyr, *Charlottesville*
Ramaswamy, Isabel Jamili, *Arlington*
Ramirez, Colin Edward, *Staunton*
Ramiscal, Erlinda R, *Virginia Beach*
Ramos-Lopez, Severina R, *Richmond*
Ranade, Nalini Maheshwar, *Waynesboro*
Raney, Richard Beverly Jr, *Charlottesville*
Rannings, Dolores Ann, *Keswick*
Rathke, Charles Ernest, *Manassas*
Rayos, Julie Rosete, *Forest*
Reams, Patricia N, *Richmond*
Reardon, Eileen Mary, *Arlington*
Reardon, Patrick A, *Petersburg*
Recinos, Adrian Jr, *Falls Church*
Rees, William Charles, *Burke*
Reese, David J, *Arlington*
Reing, Cornelius M Jr, *Annandale*
Reynolds, David Nevina, *Charlottesville*
Richmond, Marion D, *Martinsville*
Rider, Robert Edward, *Martinsville*
Riegle, Carolyn Mary, *Norfolk*
Ripberger, Frank M, *Charlottesville*
Rivadeneira, Colon, *Mechanicsville*
Rizzo, William Bradley, *Midlothian*
Roberts, Robert J, *Ivy*
Robinson, Grover C III, *Richmond*
Robinson, Margaret Rose, *Radford*
Robison, William H, *Roanoke*
Rodgers, Stephen Quarles, *Virginia Beach*
Rodriguez, Bella R, *Woodbridge*
Rodriguez, Gilberto E, *Richmond*
Rogers, Henry Moore Jr, *Norfolk*
Rogers, John F, *Richmond*
Rogin, Glenn David, *Clifton Forge*
Rogol, Alan D, *Charlottesville*
Rohn, Reuben D, *Norfolk*
Roos, Carlton Friedrich, *Richmond*
Rosch, Jeffrey Marvin, *Williamsburg*
Ross, Wanda Sawyer, *Richmond*
Roth, Karl Sebastian, *Richmond*
Roycroft, Elizabeth Weick, *Martinsville*
Rozycki, Henry Joseph, *Richmond*
Rubio, Thomas, *Norfolk*
Rudlin, Craig Reid, *Richmond*
Ruff, Mary Lee, *Newport News*
Runkle, Beatriz Pamela, *Reston*
Russell, Edward Clifton, *Richmond*
Russo, Vojislava C, *Great Falls*
Russotto, Joseph A, *Hampton*
Ryan, Enda Kieran, *Alexandria*
Ryan, Mary C, *Reston*
Ryan, Richard Herrick, *Alexandria*
Sadr, Manijeh, *Fairfax*
Saether-Vranjican, Linda M, *Franklin*
Sager, William Laird, *Danville*
Sakhadeo, Shrihari S, *Petersburg*
Salsbury, Carl A, *Falls Church*
Sandiford, Patricia Carol, *Annandale*
Sankaran, Kalathil N, *Suffolk*
Sankaran, Nellie M, *Suffolk*
Santa Ana, Patrocinio P, *McLean*
Sapra, Parmod Kumar, *Norton*
Saraiya, Raksha S, *Norton*
Sargeant, Daniel Trigg Jr, *Charlotesville*
Sarodi, Sikander Sultana, *Arlington*
Saulsbury, Frank T, *Charlottesville*
Saunders, Martha Key, *Richmond*
Schiavone, Daniel C Jr, *Winchester*
Schlein, Paul Arthur, *Richmond*
Schmidt, Mary Elizabeth, *Alexandria*
Schneider, F Carl, *Falls Church*

Pediatrics *(cont'd)*

Schoonover, Lynne Mary, *Falls Church*
Schulwolf, Alfred Morton, *Virginia Beach*
Schwartz, Richard H, *Vienna*
Schweisthal, Paul Edward, *Vienna*
Schwersenski, Jeffrey, *Richmond*
Scott, Hope Taylor, *Great Falls*
Seetharam, Malavalli N, *Chesterfield*
Seidman, Laurence Alan, *Arlington*
Seiler, Ira, *Springfield*
Selden, Robert F Jr, *Charlottesville*
Shah, Kiritkumar N, *Virginia Beach*
Shahin, Bahman, *Vienna*
Shalf, Jerome M, *Ashland*
Shanahan, Sheila A, *McLean*
Shashaty, Nancy Packert, *McLean*
Shaw, Jacqueline Denise, *Richmond*
Shayne, Robert Steven, *Chester*
Shelton, Jean Elizabeth, *Suffolk*
Shepherd, George B, *Virginia Beach*
Shepherd, Larry Mason, *Luray*
Shindler, Elliott R, *Colonial Heights*
Shoaibi, Ahmad, *Norfolk*
Shreve, J Mark, *Richmond*
Shropshire, Lowry C, *Richmond*
Shu, San-Ging, *Williamsburg*
Shula, Thomas J, *Richmond*
Sidhu, Dilbagh Singh, *Fairfax Station*
Siegel, David Alan, *Burke*
Siegmund, Rita Wiegner, *Colonial Heights*
Silk, Alan Edward, *Fairfax*
Sims, Arthur I, *Arlington*
Siri, Chakkris, *Hopewell*
Siri, Charuwan, *Hopewell*
Sivit, Carlos Jesus, *Arlington*
Skansi, Viviana, *Virginia Beach*
Skoloff, Joseph S, *Sterling*
Smith, Deborah Elizabeth, *Charlottesville*
Snyders, Glenn Charles, *Virginia Beach*
Soha, Mary Elizabeth Smith, *Richmond*
Solhaug, Michael, *Norfolk*
Solomon, Stuart, *Richmond*
Soloria, Perla J, *Portsmouth*
Song, Soon-Bock Kim, *Lynchburg*
Sorrels, Karen Campbell, *Richmond*
Spence, John Edward, *Richmond*
Spencer, Edward Monroe, *Bluefield*
Spencer, Harrison C, *Abingdon*
Spencer, William P, *Abingdon*
Spicuzza, Thomas J, *Waynesboro*
Spiegel, Albert III, *Fairfax*
Spillman, James Blair, *Radford*
Spool, Maxine, *Virginia Beach*
Sprague, Dennis Michael, *Newport*
Sprague, James Baird, *Mc Lean*
Sprague, Patty Chitwood, *Newport*
Springer, Marianne Gail, *Virginia Beach*
Sproul, George Thomas, *Staunton*
Sreenivasan, Nirmala, *Wise*
Stallings, James H Jr, *Falls Church*
Stallings, Valerie A, *Norfolk*
Stein, Charles Alan, *Culpeper*
Steinberg-Karp, Glenda Sharon, *Virginia Beach*
Stern, Donald Ray, *Roanoke*
Stewart, Gary S, *Lynchburg*
Stewart, Lauraine M, *Midlothian*
Stiegler, Charles F, *Falls Church*
Stiff, Minnie Artis, *Hampton*
Stockberger, Lynn P, *Newport News*
Stone, Frank Joseph, *Ivor*
Stoneburner, Frances M, *Danville*
Strauss, Patricia Mcauliffe, *Charlottesville*
Strehler, Paul Mcgaffey, *Richmond*
Strope, Gerald Leland, *Norfolk*
Strotmeyer, Pamela, *Virginia Beach*
Sullivan, Thomas Joseph, *Alexandria*
Sutphen, James Leonard, *Charlottesville*
Svidro, Virginia Mary, *Richmond*
Swedo, Susan Anderson, *Lorton*
Sweeney, John R, *Virginia Beach*
Swoboda, Ishild Johanna, *Fairfax*
Takagi, Yasuaki Jr, *Fairfax*
Takakuwa, Toshio, *Fairfax*
Talib, Sawsan Attia, *Springfield*
Tan-Gatue, Leonardo G, *Woodbridge*
Teague, William Gerald Jr, *Charlottesville*
Teasley, Jean Elizabeth, *Richmond*
Terry, Charles V, *Richmond*
Tetteyfio, Geoffrey A, *Herndon*
Thein, Maung H, *Suffolk*
Thomas, John A, *Virginia Beach*
Thomason, Phillip Ray, *Portsmouth*
Thompson, William F, *Fairfax*
Tina, Leticia Ubaldo, *McLean*
Tipton, Gary A, *Newport News*
Tisdale, Samuel A Jr, *Richmond*
Toczek, Ariadne E Mayakis, *Alexandria*
Todhunter, Richard Boyd, *Fairfax*
Toland, Joseph, *Norfolk*
Tomlinson, Gail Elizabeth, *McLean*
Tompkins, Dorothy G, *Charlottesville*
Tompkins, James Langhorne, *South Boston*
Trabert, Richard Eric, *Annandale*
Trail, De Anna Lynne, *Norfolk*
Tremols, Guillermo Antonio, *Annandale*
Tsou, Anthony Y, *Falls Church*
Tuholski, Nancy Lee, *Arlington*
Turk, William Richard, *Charlottesville*
Uong, Alice A, *McLean*
Upshur, Marshall Leroy, *Alexandria*
Uy, Rosalina S, *Norfolk*
Varandani, Chanda, *Pennington Gap*
Vedhanayakam, A M, *Wise*
Venkatesan, Saileela, *Virginia Beach*
Villavicencio, O E, *Annandale*
Vinson, Charlie Stephen, *Virginia Beach*
Vogel, Ruth, *Virginia Beach*
Wahl, Nancy Grant, *Richmond*
Walke, John Tabb, *Salem*
Walker, James Callan, *Charlottesville*
Walker, Paul, *Newport News*
Walker, Timothy Stuart, *Radford*
Ward, Deborah Williams, *Richmond*
Wassum, Charles S III, *Springfield*
Watson, Charles H II, *Falls Church*
Watson, John Kenyon, *Portsmouth*
Watson, Mary Mahany, *Portsmouth*
Watts, Elizabeth Hess, *Vienna*
Way, William Greene, *Winchester*
Webb, Charles R, *Alexandria*
Weinberg, Herbert L, *Suffolk*
Weinstein, Julian, *Richmond*
Weinstein, Samuel, *Fairfax*
Weirick-Sacks, Gunvor Elizabeth, *Richmond*
Weiss, Juan E, *Wytheville*
Welch, Nancy M, *Chesapeake*
Wells, Hugh H, *Roanoke*
Wells, James Morgan, *Richmond*
Werthmann, Milton W Jr, *McLean*
West, Bruce Stewart, *Richmond*
Wheeler, Acquenetta Vernecia, *Springfield*
Whitaker, Joyce L, *Richmond*
White, Forrest P, *Norfolk*
Whitehead, Betty, *Chatham*
Wiesinger, Ronald Joseph, *Falls Chruch*
Wijetilleke, Padma Piyaseeli, *McLean*
Wijetilleke, Rohini, *McLean*
Wiley, Edward James Jr, *Richmond*
Wilkerson, Vivian Myrtle, *Fort Lee*
Williams, Elizabeth Kennon, *Batesville*
Willson, Douglas Frederick, *Charlottesville*
Wilmot, Benneville Dayton, *Alexandria*
Wilson, David Cole III, *Charlottesville*
Wilson, William G, *Charlottesville*
Wineland, Robert K, *Alexandria*
Wirth, Frederick H Jr, *Virginia Beach*
Wise, James Lafayette Jr, *Charles City*
Witt, Mary Frances, *Richmond*
Wolf, Barry, *Richmond*
Woodford, Renee Aline, *Arlington*
Wooding, Clinton H Jr, *Portsmouth*
Woods, Andrew Michael, *Charlottesville*
Wright, Melville G III, *Fredericksburg*
Wright, Nellie D, *Lebanon*
Wynne, Conrad Valentino Jr, *Salem*
Yang, Emma Uy, *Burke*
Yates, Harold T, *Alexandria*
York, Lester Arthur III, *Springfield*
Young, Delosa Anthony, *Springfield*
Young, Reuben Barnes, *Richmond*
Young, Winfield Anthony, *Virginia Beach*
Zachary, John Stephen, *Midlothian*
Zajdowicz, Margan Jamieson, *Norfolk*
Zanga, Joseph Robert, *Richmond*
Zedd, Arnold J, *Portsmouth*
Zeh, Debra Anne, *Fairfax*
Ziai, Mohsen, *Falls Church*
Ziegler, John Marshall, *Charlottesville*
Ziegler, Judy Price, *Charlottesville*
Zilliox, Ann Philomena, *Newport News*
Zuckerman, Lilly Liu, *Arlington*

Physical Medicine/Rehabilitation

Ashley, John T, *Charlottesville*
Bagby, Bathurst B Jr, *Kilmarnock*
Berman, William S, *Falls Church*
Bonner, Charles H, *Richmond*
Cherrick, Abraham A, *Falls Church*
Cohen, Charles Albert, *Richmond*
Coplin, Bruce Morris, *Richmond*
Cross, Leland L, *Charlottesville*
Decker, Michael John, *Richmond*
Dixon, Ernest Malcolm, *McLean*
Dorfman, Daniel Marc, *Richmond*
Drennan, Dale C, *Alexandria*
Eapen, Sari, *Emporia*
Friedlis, Mayo, *Falls Church*
Gashi, Faton, *Oakton*
Gibbs, Lucy Hodnette, *Lynchburg*

Physical Medicine/Rehabilitation *(cont'd)*

Gisolfi, Roger Vincent, *Fairfax*
Grant, Kathryn E, *Arlington*
Green-Mack, Thelma L, *Norfolk*
Griffith, Mark D, *Roanoke*
Jena, Tripti B, *Richmond*
Jessee, Robert William, *Hanover*
Kim, Hie Chul, *Springfield*
Knudson, A B C, *Fairfax Station*
Kumar, Achla, *Norfolk*
La Fratta, Carl W, *Richmond*
Lamb, Charles R Jr, *Chester*
Lewis, Verna Mae, *Daleville*
Maurath, Katherine L, *Annandale*
Meythaler, Jay Merlin, *Charlottesville*
Mondall, Philip Jr, *Falls Church*
Oh, Sai H, *Blacksburg*
Page, Sidney G, *Richmond*
Park, Herbert William, *Richmond*
Parker, Kenneth R, *Alexandria*
Patel, Sohini P, *Annandale*
Pruna, Olga R, *Falls Church*
Reynolds, Robert E, *Charlottesville*
Ross, Mark A, *Newport News*
Rucker, Karen Snowden, *Richmond*
Sheridan, Carol Dinkelacker, *Annandale*
Shin, Wan, *Falls Church*
Sidhu, Jatinder K, *Colonial Heights*
Singer, Janet Grey, *Falls Church*
Smokvina, Marija Demsar, *Mc Lean*
Stonnington, Henry H, *Richmond*
Tuel, Stephen Michael, *Charlottesville*
Vijayaraghava, Malur Ramanna, *Richmond*
Wade, Walter Harold, *Norfolk*
Walsh, Zane Thomas, *Richmond*
Wayne, Douglas A, *Midlothian*
Wilson, Terrence James, *Chesapeake*
Witten, Celia Margot, *Manassas*
Zasler, Nathan D, *Richmond*
Zohn, David Arthur, *Mc Lean*

Plastic Surgery

Adamson, Jerome E, *Norfolk*
Albert, L Thomas, *Fredericksburg*
Alexander, John E, *Locust Grove*
Austin, Harvey W, *McLean*
Bestler, J Michael, *Martinsville*
Billet, Adam, *Norfolk*
Block, Leon Irving, *Falls Church*
Borges, Albert Facundo, *Falls Church*
Bringelsen, Karen Ann, *Charlottesville*
Brobst, Henry Thomas, *Roanoke*
Carney, Martin J, *Virginia Beach*
Carraway, James Howard, *Norfolk*
Carrico, Thomas J, *Richmond*
Chopra, Surrinder K, *Bluefield*
Chow, Jimmy Alastair, *Falls Church*
Climo, Merrill Salem, *Arlington*
Climo, Samuel, *Locust Grove*
Cohen, Irwin Kelman, *Richmond*
Coleman, Claude C Jr, *Richmond*
Custalow, Linwood W, *Newport News*
Dempsey, William Charles, *Fairfax*
De Wire, Thomas Merrill, *Richmond*
Duda, Gloria, *Arlington*
Edgerton, Milton T, *Charlottesville*
Erhardt, Walter L Jr, *Norfolk*
Fleury, Albert Fenwick Jr, *Annandale*
Freeman, Bruce G, *Roanoke*
French, James Harold Jr, *Annandale*
Fuller, Samuel P, *Lynchburg*
Gilbert, David Alan, *Norfolk*
Giunta, Joseph Liborio, *Manassas*
Gomuwka, Patricia K, *Newport News*
Grenga, Tad Edward, *Portsmouth*
Hirschberg, Stanley M, *Winchester*
Hodgkinson, Darryl J, *Williamsburg*
Horton, Charles Edwin, *Norfolk*
Jacobs, Jonathan S, *Norfolk*
Jankauskas, Saulius J, *Powhatan*
Kadesky, Yale M, *Alexandria*
Kang, Young Sup, *Roanoke*
Lanzalotti, John Allen, *Williamsburg*
Magassy, Csaba Ladislao, *McLean*
Magee, William P Jr, *Norfolk*
Maragh, Hallene A, *Norfolk*
Matini, Khosrow, *Alexandria*
Mc Arthur, Alexander III, *Newport News*
Mc Craw, John Barry, *Norfolk*
Mc Knelly, Larry Oren, *Alexandria*
Mehrhof, Austin I Jr, *Richmond*
Merrell, J Craig, *Portsmouth*
Merritt, Wyndell H, *Richmond*
Mladick, Richard Anthony, *Virginia Beach*
Moore, Thomas S, *Lynchburg*
Moorman, Warren L, *Salem*
Morgan, Elizabeth, *McLean*
Morris, James Culvin III, *Roanoke*
Morris, Richard Louis, *Virginia Beach*
Mosely, Linda Hays, *Alexandria*
Munasifi, Talal A, *Arlington*
Olshansky, Kenneth, *Richmond*
Petty, Carroll Thomas, *Richmond*
Pozez, Andrea Lee, *Richmond*
Price, Gordon Wesley, *Annandale*
Redman, Richard Don, *Richmond*
Reichel, Carol A, *Salem*
Roth, Robert Frank, *Salem*
Rowe, Douglas Stephen, *Richmond*
Ruffin, Willcox Jr, *Virginia Beach*
Sauer, Paul Frederick, *Richmond*
Schnarrs, Robert Harold, *Norfolk*
Schuler, Frank A III, *Newport News*
Schultz, Joyce A, *Harrisonburg*
Sendi, Houchang, *Alexandria*
Shapiro, Carol Sadie, *Woodbridge*
Shepard, Glenn Harvey, *Newport News*
Siegel, Fred H, *Chesapeake*
Silberblatt, Enrique A, *Roanoke*
Silvester, Timothy James, *Lynchburg*
Smith, Leroy, *Richmond*
Teasley, David George, *Williamsburg*
Terzis, Julia K, *Norfolk*
Teunis, Bernard S, *Mc Lean*
Vonu, Peter J, *Hampton*
Ware, James Latane, *Richmond*
Weston, George Weedon, *McLean*
Whipple, George Albert, *Fairfax*
Williams, Gaylord Stone, *Charlottesville*
Williams, Mason Miller, *Richmond*
Wilson, Henry H Jr, *Richmond*

Psychiatry

Abdou, Fathy A, *Virginia Beach*
Abraham, Samathanam Nithiyanandan, *Portsmouth*
Abse, David Wilfred, *Radford*
Agarwal, Kamala, *Colonial Heights*
Agarwal, Ramesh C, *Colonial Heights*
Akhtar, Saleha Siddiqui, *Alexandria*
Albright, David Wesley, *Richmond*
Aldrich, Clarence Knight, *Charlottesville*
Alexander, Robert Clifton, *Alexandria*
Ali, Alan Hassan, *Williamsburg*
Anderson, Allan A, *Nassawadox*
Andres, Francis Dimmick, *Annandale*
Angliker, Colin C J, *Marion*
Annibali, Joseph A, *McLean*
Armstrong, Richard H, *Richmond*
Arons, Michael J, *Reston*
Ashby, B R, *Danville*
Ashman, Stuart, *Virginia Beach*
Atri, Padmini B, *Richmond*
Aujla, Sarbjit Singh, *Salem*
Azmayesh-Fard Esmaili, Fakhrolsadate Haydeh, *Franklin*
Bailey, James Paul, *Hampton*
Baker, Bruce Edward, *Fredericksburg*
Ballon, Lawrence M, *Arlington*
Bar-Levav, Leora Prina, *Arlington*
Barber, Jack Willard, *Charlottesville*
Barnard, John W, *Portsmouth*
Barquist, Walter Eric, *Reston*
Baskett, Sarah Josephine, *Mechanicsville*
Basta, Barbara Josephine, *Arlington*
Batte, William Henry, *Norfolk*
Beachy, Natalie Anne, *Charlottesville*
Behrmann, Arthur E, *Dunn Loring*
Beltran, Romulo G, *Lynchburg*
Berkey, Barry Robert, *West Springfield*
Berkowitz, Alan Michael, *Washington*
Berman, Jacob Henry, *Virginia Beach*
Bernert, Lawrence A Jr, *Norfolk*
Berry, Carlos Eugenio, *Falls Church*
Bick, Michael S, *Richmond*
Biddlestone, William Robert, *Danville*
Binford, Charles A, *Midlothian*
Birashk, Kambiz, *Springfield*
Blackman, Jerome S, *Virginia Beach*
Blair, Walter Bernard, *Salem*
Blair, William F, *Norfolk*
Blakey, Hubert H, *Alexandria*
Blank, Alvin Robert, *Virginia Beach*
Blankinship, Rex, *Richmond*
Blitch, James Bedford Jr, *Reston*
Block, David A, *McLean*
Blum, Joel Alan, *Richmond*
Boas, Anne, *McLean*
Bockner, Andrew Charles, *Roanoke*
Boger, David Sprott, *Arlington*
Boggiano, William Edward, *Alexandria*
Bolter, Delano Woodrow, *Marion*
Borensztein, Liliana Letzen, *Alexandria*
Boruchow, Lillibeth B, *Arlington*
Boruchow, Sheldon, *Arlington*
Bottlinger, Bruce J, *Richmond*
Bottlinger, Jane Holtzclaw, *Richmond*
Bouton, Brian B, *Charlottesville*
Bowen, Henry A, *Richmond*
Bowers, Margaretta K, *Accomac*
Bram, Frederick M, *Fredericksburg*
Brand, Eugene D, *Kilmarnock*

Psychiatry *(cont'd)*

Breslin, Nancy A, *Alexandria*
Bressler, Bernard, *Richmond*
Brewer, Jack R, *McLean*
Brewer, Virginia S, *McLean*
Broadhead, Daniel D, *Falls Church*
Brodie, Owen Wingfield, *Richmond*
Brooks, George K Jr, *Richmond*
Brooks, Kenneth Phillip, *Richmond*
Brosnan, Kathleen Angela, *Richmond*
Brown, D Earl Jr, *Reston*
Brown, Michael David, *Falls Church*
Brown, Robert Stanley, *Charlottesville*
Buchanan, John Goodwin, *Virginia Beach*
Buongiorno, Paul A, *Fairfax*
Burdick, Edward P, *Poquoson*
Burns, Julia Wilkerson, *Richmond*
Butcher, Ronald H, *Richmond*
Buxton, Martin N, *Richmond*
Buxton, William Dimmock, *Crozet*
Cafiero, Louis, *Virginia Beach*
Camp, Norman M, *Richmond*
Campden-Main, Brian C, *Fairfax*
Canizares, Felipe Garcia, *Roanoke*
Canterbury, Randolph Jack II, *Earlysville*
Carosella, Nicholas William, *West Springfield*
Carroll, William J, *Williamsburg*
Cauble, Steven L, *Richmond*
Cavender, William Francis, *Alexandria*
Charney, David L, *Alexandria*
Chaudhary, Nazir Ahmad, *Richmond*
Cheatham, William J, *Marion*
Chellappan, Anandababu, *Chesterfield*
Chessen, Douglas Howell, *Newport News*
Chitwood, Sarah R, *Draper*
Choksi, Jayendra C, *Falls Church*
Christian, Charles Fletcher, *Richmond*
Cimonetti, Thomas Curran, *Norfolk*
Clark, Nancy C, *Alexandria*
Clarkson, William David, *Salem*
Cohen, Cynthia Jane Goldstein, *Arlington*
Cohen, Howard Jay, *Alexandria*
Colenda, Christopher C III, *Richmond*
Collins, Phil, *Charlottesville*
Concepcion, Nicanor Bolintiam, *Norton*
Conell, Lawrence J, *Fredericksburg*
Conley, Eugene Joseph, *Alexandria*
Cooper, Alan Michael, *Lynchburg*
Corcoran, James F T, *Richmond*
Cornell, Christy E, *Alexandria*
Cornet, Antoine Parnell, *Springfield*
Cortina, Jorge Alberto, *Charlottesville*
Crow, Byron P, *Salem*
Crowe, David Barr, *Arlington*
Cruser, Fred S, *Salem*
Cseh, William Michael, *Newport News*
Curtis, Richard E Jr, *Richmond*
Dabney, John Otis, *Norfolk*
Dang-Vu, Chan, *Falls Church*
Daniel, David G, *Alexandria*
Darby, Daniel L, *Virginia Beach*
Daum, Conrad Henry, *Salem*
David, Joseph Jordan, *Charlottesville*
Davies, John Benjamin, *Alexandria*
Davis, Charles Monroe, *Richmond*
Davis, Donald Irvin, *Alexandria*
Dee, James Francis, *Alexandria*
Del Alcazar, Antonio W, *Hampton*
Del Vecchio, Michael Alfred, *Vienna*
Delaney, Martin Donohue III, *Alexandria*
Deporter, Thomas Elden, *Charlottesville*
Desai, Jitendra S, *Roanoke*
Desolminihac, Marc C, *Norfolk*
De Verter, John Scott, *Salem*
Diaz, Michael Adolph, *Reston*
Dietzgen, Walter A, *Hampton*
Dileo, Leonard M, *Suffolk*
Dim, Bomen Hifzi, *Falls Church*
Dimitris, James C, *Richmond*
Dimmett, James David, *Williamsburg*
Dommisse, John, *Portsmouth*
Donskoy, Betty Schnur, *Fairfax*
Dort, Charles Webb, *Earlysville*
Doss, Anthony E, *Chilhowie*
Doss, Julian Booth, *Roanoke*
Douglas, William W, *Salem*
Doum, John M, *Onancock*
Dozoretz, Ronald Irving, *Norfolk*
Driver, Samuel Francis, *Roanoke*
Dubin, Gerald H, *Great Falls*
Dubner, Neil P, *Radford*
Duffy, Adrian Dominick, *Annandale*
Duffy, Eileen J, *Great Falls*
Dundon, Suzanne E, *Norfolk*
Durell, Jack, *McLean*
Durkin, James Patrick, *Arlington*
Durr, Michael Joseph Jr, *Falls Church*
Durrani, Abdul W, *Hopewell*
Dykes, Reno Jackson Jr, *Manassas*
Eagle, John Russell, *Harrisonburg*
Eden, James Arthur Jr, *Pembroke*
Elias, William Sliman, *Roanoke*
Emiliani, N A, *Colonial Heights*
Evangelista, Leah Norona, *Vienna*
Everett, Anita Smith, *Charlottesville*
Ewell, Cleve Winfield, *Virginia Beach*
Faber, David Ray II, *Norfolk*
Fakhre-Shafaie, Aflatoon, *Williamsburg*
Falcon, Hugo G, *Burkeville*
Falcon, Soledad M, *Burkeville*
Fehr, Randall William, *Richmond*
Feldman, Frances R, *Williamsburg*
Felker, Bradford Laird, *Charlottesville*
Fernando, Thomas G, *Norfolk*
Fink, Ludwig, *Falls Church*
Fischer, Daniel Edward, *Virginia Beach*
Fisher, Dorothy Gwendoline, *Richmond*
Fisher, John Gregory, *Chester*
Fodor, Frank, *Catawba*
Fogg, Philip S Jr, *Roanoke*
Foster, Douglas Goddard, *Leesburg*
Foster, Helen M, *Richmond*
Foster, Merritt W Jr, *Richmond*
Frank, Randolph Adams, *Charlottesville*
Frank, William George, *Alexandria*
Friedel, Robert O, *Richmond*
Friedenberg, Milton David, *Richmond*
Furr, John H, *Norfolk*
Gaertner, William Ronald, *Richmond*
Gardner, Robert D, *Lynchburg*
Garner, David S, *Roanoke*
Garnett, Richard W Jr, *Charlottesville*
Garson, Ronald J, *Leesburg*
Gebara, David J, *Falls Church*
Gibbs, William F, *Norfolk*
Giese, Alexis Anne, *Arlington*
Gilbert, Roberta Mae, *Falls Church*
Gill, Baljit Singh, *Grafton*
Giller, Martin, *Alexandria*
Gillespie, Hal Gravley, *Radford*
Glasgow, Jean M, *Roanoke*
Gleason, Margaret Daley, *Richmond*
Glick, Joseph L, *Harrisonburg*
Gobar, Asad H, *Annandale*
Goldstein, Leonard Steven, *Fairfax*
Goodenow, Willis G, *Charlottesville*
Gorman, Barry Charles, *McLean*
Graham, Marlon Anthony, *Marion*
Granger, Martha E, *Alexandria*
Grau, Joseph Grayson, *Newport News*
Gray, Bruce M, *Winchester*
Greco, Philip Scot, *Alexandria*
Green, Elaine R, *Alexandria*
Greenblum, Lucie, *Arlington*
Grey, William Hugh, *Staunton*
Grigg, Jon Richard, *Norfolk*
Griswold, James Francis, *Virginia Beach*
Guarino, Walter C, *Vienna*
Gurdziel, Gloria K, *Virginia Beach*
Hacker, John F, *Roanoke*
Hansen, Hobart G, *Staunton*
Harelick, Marjorie Alma, *Arlington*
Harindran, Usha Janardhanan, *Chesterfield*
Harp, William Lee, *Richmond*
Harris, L Martin, *Richmond*
Hartman, David W, *Roanoke*
Haskins, Barbara Gay, *Charlottesville*
Hays, Jack Mizell, *Williamsburg*
Hearst, Earl David, *Virginia Beach*
Heath, John Francis, *McLean*
Hecker, Carlos Metsch, *Alexandria*
Heller, Jay Ronald, *Charlottesville*
Hengst, Arno Diedrich, *Lynchburg*
Henriquez, Norma, *Portsmouth*
Hertzberg, Michael, *Alexandria*
Hill, Trafford Jr, *Virginia Beach*
Hirschman, Bernardo, *Fairfax*
Hoang, Truong Xuan, *Williamsburg*
Hochheiser, Joseph H, *Richmond*
Hodges, Emory Falcon Jr, *Alexandria*
Hoffman, Ivan Bruce, *Richmond*
Hoffman, Michael A, *Staunton*
Holmes, James H, *Portsmouth*
Hovermale, Lisa Simone, *Charlottesville*
Howerton, James Robert, *Newport News*
Hoyer, David J, *Danville*
Hryvniak, Michael Russell, *Fairfax*
Huang, Kun-Huang, *McLean*
Hucek, Andrew M, *Charlottesville*
Hull, George H, *Roanoke*
Hurt, John Omohundro Jr, *Salem*
Hutchison, David, *Charlottesville*
Isidro, Rose Marie, *Clifton*
Isrow, Larry Alan, *Richmond*
Jacob, Thomas N, *Great Falls*
Jennings, Walter S Jr, *Richmond*
Johnson, Matthew Lee, *Charlottesville*
Johnson, Robert W, *Annandale*
Johnson, Wade Ln, *Newport News*
Johnston, Randolph P, *Winchester*
Jones, Donald K, *Richmond*
Jones, William Bailey III, *Alexandria*

Psychiatry *(cont'd)*

Joseph, Antony, *Richmond*
Josephthal, Daniel Herbert, *Charlottesville*
Joyce, D Jill, *Alexandria*
Julius, Demetrios Aristides, *Richmond*
Kaplin, Arnold Jay, *Alexandria*
Karpati, Steven G, *Alexandria*
Kasinoff, Bernard H, *Abingdon*
Kasper, John Andrew Jr, *Charlottesville*
Kay, Earl Daniel Jr, *Chesapeake*
Keats, Matthew Mason, *Virginia Beach*
Kernodle, Judith M, *Richmond*
Kernodle, William Dwight, *Richmond*
Kessler, Kenneth A, *Arlington*
Ketcham, Robert E, *McLean*
Khalily, Cyma, *Richmond*
Khot, Vikram Sidharth, *Alexandria*
Kibbe, Milton H, *Radford*
Kiczales, Adolphe Charles, *Winchester*
Kim, Jin Tek Jr, *Midlothian*
King, James P, *Radford*
Kirven, Leo Edwin Jr, *Williamsburg*
Klein, Wendy Simons, *Richmond*
Kling, Suzanne K, *Falls Church*
Klinger, Rochelle L, *Richmond*
Kobylski, Thomas Paul Jr, *Arlington*
Koduri, Ramesh Babu, *Petersburg*
Koduru, Banerje, *Petersburg*
Koller, Miriam M, *Richmond*
Kololgi, Sunil Vishwanath, *Richmond*
Kornbluth, Ralph R, *Fairfax*
Kornstein, Susan Gaye, *Richmond*
Kottaram, Sibi Joseph, *Abingdon*
Kruger, David B, *Norfolk*
Labelle, Ellen J, *Arlington*
Lassen, Thorbjorn Johan, *Newport News*
Laster, James Monroe, *Virginia Beach*
Lauter, Jonathan Benjamin, *Annandale*
Leadbetter, Robert Annon, *Charlottesville*
Lebuffe, Francis Peter, *Falls Church*
Lee, Bong-Kee, *Burke*
Lee, Kyung Ja Shin, *Alexandria*
Lefko, Andrew G, *Hampton*
Levenson, James Lloyd, *Richmond*
Levey, Bernard, *Richmond*
Lexier, Lenard Jay, *Norfolk*
Licata, Robert M, *McLean*
Lindsay, Rebecca Jane, *Charlottesville*
Litovitz, Gary Lane, *Annandale*
Little, Teruko O, *Richmond*
Liverman, Joan Hulley, *Richmond*
Lizer, James Robert, *Leesburg*
Longan, Robert C Jr, *Richmond*
Lordi, William M, *Richmond*
Lorio, Joseph Philibert, *Annandale*
Luedke, George William, *Roanoke*
Luisada, Paul V, *Alexandria*
Lumba, Gerardo Foronda, *Petersburg*
Magier, Igor, *Chesapeake*
Magier, Nina G, *Roanoke*
Mainfort, Jack Randolph, *Farmville*
Majewski, Patricia Ann, *Falls Church*
Makarowsky, Eugene, *Richmond*
Marcus, Ronald Alan, *Norfolk*
Margoshes, Barton Gray, *Richmond*
Marienfeldt, Hans F, *Salem*
Markowitz, David Jeffrey, *Richmond*
Masotti, George M, *Williamsburg*
Masri, Asad M, *Petersburg*
Master, Sherman, *Richmond*
Mattich, Angelo, *Annandale*
Mayberry, Alton R, *Roanoke*
Mc Daniel, William Windsor, *Norfolk*
Mc Elroy, Sandra Neskorik, *Richmond*
Mc Entire, Wesley Edward, *Richmond*
Mc Farland, John W, *Arlington*
Mc Kelway, Russell Brick, *Charlottesville*
Mc Kenzie, Norma Deeann, *Midlothian*
Mc Knight, Russell D, *Norton*
Mc Lean, Mary Susan, *Richmond*
Mc Mahon, George Joseph, *Annandale*
Mehta, Ravindra Kumar, *Salem*
Melmed, Allan Stanley, *Falls Church*
Mendez, Giotto A, *Fairfax*
Mika, David Bedrick, *Charlottesville*
Miles, William, *Hampton*
Miller, Mark Dana, *Fredericksburg*
Miller, Michael Scott, *Richmond*
Milliken, Charles S, *Colonial Heights*
Mingione, Donald Leo, *Portsmouth*
Mirmirani, Nooreddin, *Springfield*
Mishra, Asha Sharma, *Chesterfield*
Mitchell, Robert Elmer Jr, *Virginia Beach*
Moody, David T, *Charlottesville*
Mooney, Joseph, *Charlottesville*
Moore, Sarah Fietcher, *Portsmouth*
Morewitz, Jerry H, *Virginia Beach*
Mosholder, Andrew Donald, *Charlottesville*
Mostek, Walter Anthony, *Virginia Beach*
Mueller, Karl H, *Springfield*
Mulkern, Anne Marie, *Hampton*
Munoz, Hector M, *Portsmouth*
Muratorio, Jose Luis, *Fairfax*
Myers, Ronald Lee, *Radford*
Nalls, Cecil A III, *Richmond*
Navarre, Angela Sims, *Richmond*
Nelson, B W, *Richmond*
Nelson, Pierce Daniel, *Wise*
Neu, Robert Bernard, *Arlington*
Niazi, Saifullah Khan, *Richmond*
Nigro, Bernard Angelo, *Alexandria*
Novak, John Goodman, *Lynchburg*
Noveras, Teresita Lorenzo, *Virginia Beach*
Ocampo, Alexander T, *Fairfax*
O'Donnell, Daniel J, *Trevilians*
Ogram, John D, *Alexandria*
Oleary, Joseph Harry, *Annandale*
Opal, John A, *Woodbridge*
Ordonez, Mario Andres, *Alexandria*
O'Shanick, Gregory John, *Richmond*
Ostrow, Lawrence D, *Sterling*
Otey, Sarah Chitwood, *Draper*
Ozerengin, Mustafa F, *Roanoke*
Page, Catherine Marie, *Martinsville*
Pakull, Barton, *Arlington*
Palmaz, Martin, *Williamsburg*
Park, Hyungsoon Jr, *Woodbridge*
Park, Kyung Suk Kim, *Alexandria*
Patel, Chandrakant M, *Danville*
Patel, Minaben Dilipkumar, *Richlands*
Patel, Mrugendra Raojibhal, *Richlands*
Patel, Nandini Anilkumar, *Virginia Beach*
Patel, Pravinchandra C, *Danville*
Payne, John D, *McLean*
Payne, Lillian Marlene, *McLean*
Pearce, R Scott C, *Charlottesville*
Peckar, Paul J, *Alexandria*
Pelonero, Anthony Leonard, *Chesterfield*
Pepper, F Jay, *Alexandria*
Peppler, Michael D, *Norfolk*
Perkins, Marvin E, *Fincastle*
Peterson, Gregory Alan, *Charlottesville*
Phillips, Alice T, *Woodbridge*
Phillips, Joseph Donald, *Gloucester*
Piedra, Mariano M, *Richmond*
Pile, Wendell James, *Newport News*
Pines, Deborah Ann, *Arlington*
Pitrolo, David Andrew, *Chesapeake*
Plewes, John Mccauley, *Alexandria*
Pomm, Raymond Martin, *Staunton*
Posada, Alejandro Emilio, *Charlottesville*
Powell, Albert Henry Jr, *Norfolk*
Powell, Betty, *Wicomico*
Prasad, Channavajjala Mallikarjuna, *Arlington*
Prasad, Renuka N, *Danville*
Price, Neil D, *Virginia Beach*
Prochazka, Marta Anna, *Fairfax*
Puga, William Fernando, *Richmond*
Quarles, Pamela Anne, *Alexandria*
Qureshi, Minhaj H, *Richmond*
Radin, Robert P, *Arlington*
Radke, Marilyn Szymialis, *Arlington*
Ragan, Charles L II, *Dumfries*
Ramos, Emelita F, *Virginia Beach*
Rao, Neerada, *Vienna*
Ravitz, Leonard J, *Norfolk*
Raymond, Linda Gail, *Arlington*
Reddy, Pannala J, *Petersburg*
Reed, Donald L, *Fredericksburg*
Reilly, Paul David, *Williamsburg*
Reinhardt, Erich M, *Alexandria*
Reiter, Stephen Arthur, *Rochelle*
Reynolds, Brian Joe, *Vienna*
Richenstein, Victor Benjamin, *Charlottesville*
Rifkin, Robert Howard, *Charlottesville*
Ritchie, George G Jr, *Kilmarnock*
Rizvi, Carol Anne, *Falls Church*
Roath, Michael Steven, *Springfield*
Robbins, Peter Howard, *Reston*
Robinson, James P, *Hampton*
Rochmis, Ann Romatowski, *Fairfax*
Rodriguez, Linda Padilla, *Virginia Beach*
Rody, Elizabeth Joan, *Arlington*
Roebuck, Basil Enoch, *Blacksburg*
Roland, Miriam W, *Falls Church*
Rosecan, Arthur Scott, *Arlington*
Rosenthal, Steve, *Reston*
Rosin, David Aaron, *Norfolk*
Rostafinski, Michael J, *Petersburg*
Roth, Richard Lee, *McLean*
Roy, Gaston E, *Woodbridge*
Royola, Samuel A, *Richmond*
Rubinstein, Shira Hope, *Richmond*
Rucker, Morton S, *Suffolk*
Ruona, Luanne, *Alexandria*
Russell, John A Jr, *Richmond*
Saathoff, Gregory Brian, *Charlottesville*
Sacirbey, Nedzib, *Falls Church*
Sacks, Charles B, *McLean*
Sager, Alan Robert, *Fairfax Station*
Salus, Sydney Gordon, *McLean*
Sampang, Antonio Beltran, *Bristol*

Psychiatry *(cont'd)*

Sanderson, Timothy A, *Norfolk*
Sansone, Philip Andrew, *Charlottesville*
Sanz, Manuel O, *Williamsburg*
Sarvay, Thomas Long, *Roanoke*
Saunders, John Rudolph, *Richmond*
Saunders, Joyce Herrin, *Chester*
Sayegh, Paul Amin, *Norfolk*
Scavullo, Blaise, *Richmond*
Schaeffer, Geraldine, *Arlington*
Scharf, Charles Selden, *Tazewell*
Scheiderer, David Jacob, *Charlottesville*
Schiavone, Andrew Anthony Jr, *Alexandria*
Schiff, Graenum Robert, *Richmond*
Schlobohm, Philip G, *Richmond*
Schmitz, Nicholas W, *Lexington*
Schoenfeld, Rene B, *Virginia Beach*
Schreiber, Mark Traudt, *Virginia Beach*
Schreiner, Carol Anne, *Virginia Beach*
Schwartz, William, *Arlington*
Schwartzer, Joseph S, *Virginia Beach*
Schwarz, Kathleen Marie, *Charlottesvile*
Scott, Randall Abell, *Midlothian*
Segall, Errol Alan, *Fairfax*
Seigle, Eliot Brandon, *Scottsville*
Selig, Donald Joseph, *Norfolk*
Sennesh, Louise Mari, *Falls Church*
Sepic, Ljiljana V, *Virginia Beach*
Seymour, James Gordon, *Charlottesville*
Shah, Mukesh Harilal, *Grafton*
Shah, Narendra C, *Roanoke*
Shah, Ramesh A, *Petersburg*
Shaw, Donna Marie, *Clifton Forge*
Sheorn, Keyhill D, *Richmond*
Shepard, William Alphonse, *Richmond*
Sheppe, William Marco Jr, *Charlottesville*
Shield, James A Jr, *Richmond*
Short, Delmar Dean, *Troutville*
Showalter, Carl Robert, *Harrisonburg*
Sidhom, Mervat Emile/Barsoum, *Newport News*
Silverman, Joel J, *Richmond*
Silverstein, Ross Stuart, *Annandale*
Simpson, Frank B III, *Arlington*
Singh, Amar J, *Suffolk*
Singh, Neena Gurpal, *Hopewell*
Sitts, Timothy M, *Annandale*
Skolnick, Marvin Ralph, *Alexandria*
Skopek, Henry Adelbert, *McLean*
Slatkin, Stephen E, *Norfolk*
Smith, Catherine R, *Abingdon*
Smith, Joseph Froelich, *Charlottesville*
Snead, John Peyton IV, *Rixeyville*
Snyder, Bernard Melvin, *Springfield*
Soheil, Harriet, *Springfield*
Solomon, Jonathan G, *Hampton*
Solomon, Michael Apter, *Charlottesville*
Sood, Aradhana Avasthy, *Richmond*
Soverow, Gary J, *Mc Lean*
Spader, Bryan D, *Franklin*
Spangler, Ronald Lee, *Richmond*
Spanier, Elliott J, *Richmond*
Speiser, Steven Oren, *Sterling*
Spivack, Gary Robert, *Arlington*
Spradlin, W W, *Charlottesville*
Starkey, Gary Lee, *Portsmouth*
Steg, James Anthony, *Vienna*
Steg, John Paul, *McLean*
Stein, Donald Underwood, *Falls Church*
Stein, Martin Herbert, *Falls Church*
Steiner, David Andrew, *Charlottesville*
Sternberg, Michael Ross, *Woodbridge*
Stevenson, Donald V, *Norfolk*
Stevenson, Ian Pretyman, *Charlottesville*
Stokes, Hugh G Jr, *Williamsburg*
Storey, Winnifred F, *Williamsburg*
Stowell, Jeremy A, *Virginia Beach*
Strange, Robert E, *Falls Church*
Strawinsky, Eliz R Caro, *Falls Church*
Strickler, Frank Andes, *Roanoke*
Struba, Robert John, *Charlottesville*
Sutker, Lawrence H, *Staunton*
Sutton, Lewis Richard, *Clifton Forge*
Tarakji, Nael M, *Richmond*
Tavenner, John S, *Norfolk*
Teja, Jagdish S, *Charlottesville*
Thakur, Hemant Krishna, *Hampton*
Theogaraj, Janakibai, *Midlothian*
Thompson, Linda Ruth, *Bristol*
Thomson, James A Jr, *Charlottesville*
Thrasher, Patrick D, *Norfolk*
Thrasher, Robert Henry, *Norfolk*
Torres-Lisboa, Patricio, *Richmond*
Tran, Canh Quang, *McLean*
Tran, Hien Tien, *Reston*
Travis, Lon Paul, *Annandale*
Treece, Wen Hsuan Chuang, *Virginia Beach*
Trivedi, Daksha Hemant, *Richmond*
True, Peter Keene, *Portsmouth*
Tsao, Thomas K, *Virginia Beach*
Tsitos, Tony A, *Annandale*
Tuason, Amenra F, *Richmond*
Tung, Tran Minh, *Falls Church*
Tupper, Charles John Jr, *Charlottesville*
Twentyman, Scott S, *Falls Church*
Upton, David Leslie, *Alexandria*
Urbano, Maria Rosina, *Norfolk*
Vaswani, Nari P, *Falls Church*
Venes, Donald Jason, *Charlottesville*
Vizcaino, Federico, *Chesapeake*
Vliet, Elizabeth L, *Norfolk*
Vozza, Nestor C, *Richmond*
Vyas, Hasmukh Amratlal, *Grafton*
Wade, Evelyn Henry Clark, *Roanoke*
Wallace, Duncan Saron, *Virginia Beach*
Walsh, Thomas Lawrence, *Arlington*
Weeks, Ruth B, *Charlottesville*
Weiss, Howard Seth, *Virginia Beach*
Westerman, Perry Scott, *Charlottesville*
Weston, Don L, *Radford*
Whitehouse, Myra Jody, *Newport News*
Whiteman, Diana M, *Newport News*
Widra, Kenneth Alan, *Williamsburg*
Wilkins, Paul Cole, *Charlottesville*
Wilkinson, James W, *Hampton*
Williams, James Newton, *Virginia Beach*
Williams, Jeffrey Grey, *Virginia Beach*
Williams, Robert K, *Richmond*
Wimer, Mary Catherine, *Charlottesville*
Winfrey, Charles Jack, *Richmond*
Witt, Nancy May Garrett, *Fishersville*
Wittenberg, Ralph E, *Fairfax*
Wood, David John, *Alexandria*
Wood, Isaac Keith, *Richmond*
Woodside, Nina B, *Manassas*
Woodson, Frederick G, *Norfolk*
Woodson, Joseph B, *Alexandria*
Worchel, Barry Jason, *Charlottesville*
Wouters, Labora M, *Richmond*
Yank, Glenn R, *Staunton*
Yoder, Daryl H, *Lynchburg*
Yoon, Albert S, *Lynchburg*
Young, William H Jr, *Washington*
Zalis, Oreste III, *Richmond*
Zaller, Eli J, *Richmond*
Zimberg, Gary B, *Norfolk*
Zinn, Edward, *Mc Lean*

Psychiatry/Neurology

Ahad, Abdul, *Vienna*
Ammerman, Richard Gene, *Reston*
Baker, James Edward, *Williamsburg*
Baker, Stephen Robert, *Great Falls*
Barnes, James Keith, *Radford*
Bates, Harry Clark III, *Staunton*
Baughman, Earle W Jr, *Alexandria*
Bigelow, Llewellyn Barry, *Alexandria*
Boonin, Nathaniel N, *Onancock*
Braganza, Teodoro J, *Yorktown*
Brantley, Julian T Jr, *Annandale*
Brown, Gerald L, *McLean*
Burnham, Robert C, *Arlington*
Buyse, Valerie Josephine, *Annandale*
Cameron, Alan Samuel, *Vienna*
Campa, Justiniano Fernandez, *Charlottesville*
Campbell, Peter L, *Springfield*
Campbell, William Wesley Jr, *Midlothian*
Carey, Benjamin Arthur, *Virginia Beach*
Chalmeta, Alberto, *Arlington*
Chmiel, Andrew Joseph, *Vienna*
Clower, Virginia Lawson, *King William*
Coleman, Roy M, *McLean*
Connell, Michael Lee, *Marion*
Cooper, Charles Marion, *Radford*
Corrie, William Stephen, *Richmond*
Coshal, Balbir Singh, *Norfolk*
Cullander, Cecil Carleton, *Charlottesville*
Daniec, Danuta Anna, *Williamsburg*
Delawter, Hilbert Haines, *Charlottesville*
Devitt, Charles K, *Virginia Beach*
Donohue, Kevin P, *Burke*
Dovenmuehle, Robert Henry, *Danville*
Draper, Walter, *Richmond*
Dunn, Cheryl T, *Sterling*
Dunn, Churchill G II, *Leesburg*
Duval, Addison Mcguire, *Newport News*
Erfe, Jose Asperin, *Williamsburg*
Ergin, Umit C, *Williamsburg*
Ettigi, Prakash G, *Richmond*
Follansbee, John N, *Alexandria*
Forssmann-Falck, Renate, *Richmond*
Fowler, Hilton Lawrence, *Salem*
Fram, David Hirsch, *Reston*
Freeman, Rudolph Jr, *Newport News*
Frishberg, Benjamin Mark, *Falls Church*
Gilliam, John Hilliard, *Richmond*
Granoff, Abbot Lee, *Norfolk*
Guyon, Martha Sue, *Portsmouth*
Haas, Melvyn Robert, *Arlington*
Hall, George L, *Falls Church*
Hann, Milka Lisicar, *Arlington*

Psychiatry/Neurology *(cont'd)*

Hansen, Robert Blaine, *Portsmouth*
Harbison, John William, *Richmond*
Harmatuk, Frances A, *Virginia Beach*
Hegarty, Thomas Joseph, *Charlottesville*
Heidelberg, Stephanie Mcnair, *Herndon*
Hein, Peter Leo Jr, *Charlottesville*
Hernandez, Manuel O, *McLean*
Hirani, Bansilal M, *Petersburg*
Hobbs, William R, *Charlottesville*
Holland, Henry D, *Richmond*
Hoye, Clara L, *Arlington*
Jaffe, Stephen L, *Richmond*
Joseph, Mary, *Midlothian*
Kavanaugh, James G Jr, *Charlottesville*
Keeney, Dan F, *Great Falls*
Keiter, Robert Harvey, *Chesapeake*
Kelley, Arthur Evans, *Radford*
Kelly, William Eager, *Charlottesville*
Kendler, Kenneth Seedman, *Richmond*
King, Lucy Jane, *Manassas*
Knopp, James Maurice, *Churchville*
Kowler, Daniel E, *Richmond*
Kreider, Stanley J, *Virginia Beach*
Lambertson, Larry Hall, *Danville*
Lawrence, Mark Allen, *McLean*
Lee, Janet H, *Charlottesville*
Lee, Soo Ik, *Charlottesville*
Leshner, Robert Theodore, *Richmond*
Lewis, Richard Alan, *Norfolk*
Lightner, Jeffrey Kass, *Fredericksburg*
Liu, Pung S, *Colonial Heights*
Login, Ivan S, *Charlottesville*
Lothman, Eric William, *Charlottesville*
Lovko, Kenneth R, *Chesapeake*
Lucas, George J, *Roanoke*
Luna-Caro, Roberto, *Portsmouth*
Lux, Ann Mary, *Vienna*
Lynch, Alison Marah/Storrar, *Grafton*
Mansheim, Paul Adolph, *Norfolk*
Mathews, Marvin Gustavo, *Norfolk*
Mattsson, Ake, *Charlottesville*
Mittelman, Eugene, *Reston*
Mode, Arthur S, *Annandale*
Molchon, Andrew B, *Alexandria*
Morbitzer, Kurt M, *Petersburg*
Moser, Albert William, *Roanoke*
Mullaney, John, *Williamsburg*
Nelson, Kirk Lee, *Richmond*
Nickols, Jess Ralph Jr, *Fairfax*
Nio, Matthew H, *Colonial Heights*
Nissman, Harvey Leonard, *Virginia Beach*
Nuckols, John Thomas, *Roanoke*
Nunez Devillavicenci, Santiago, *Williamsburg*
O'Doherty, Desmond S, *Arlington*
Owens, Joseph Henry, *Virginia Beach*
Pal, Joginder, *Norfolk*
Palat, Govindankutty K, *Hampton*
Palmer, Richard R, *Alexandria*
Parrish, Matthew Denwood, *Alexandria*
Patel, Nagindas Lalloobhai, *Richmond*
Poe, Richard Orla, *Williamsburg*
Powell, Betty J, *Newport News*
Price, Susan Laura, *Alexandria*
Pridgeon, Rhonda Marie, *Midlothian*
Puder, Robert David, *Virginia Beach*
Rabinowitz, Seymour, *Charlottesville*
Reid, David William, *Norfolk*
Rennebohm, John Alwin, *Roanoke*
Rheuban, William J, *Charlottesville*
Richardson, Mark Allen, *Norfolk*
Robbins, Kenneth X, *Alexandria*
Robertson, Alan Grant, *Richmond*
Robertson, Robert Hood, *McLean*
Robinson, David Wells, *Roanoke*
Rodriguez, Luis C, *Portsmouth*
Rogers, John Raymond, *Fairfax Station*
Royal, Orren Leroyce, *Radford*
Rudd, Steven Michael, *Arlington*
Rudolph, Robert R, *Roanoke*
Rushia, Mary Anna, *Charlottesville*
Ryans, Miller M, *Petersburg*
Sams, James C, *Scottsville*
San Clemente, Joseph Paul Jr, *Virginia Beach*
Santora, Philip J, *Falls Church*
Sarnes, Martin H, *Fairfax*
Scharf, Mary Hasner, *Tazewell*
Schmidt, Kurt T, *Williamsburg*
Schroeder, Gisela, *Clifton*
Scott, Morgan E, *Radford*
Semchyshyn, George O, *Falls Church*
Shapiro, Steven Malcolm, *Richmond*
Shemo, John P, *Charlottesville*
Shemo, Mary Carroll, *Charlottesville*
Shenoy, Ramakrishnan S, *Richmond*
Sigmund, Linda Susan, *Alexandria*
Silberman, Henry K, *Richmond*
Silver, David Freeman, *Charlottesville*
Sjolund, George C, *Virginia Beach*
Sood, Rakesh K, *Richmond*
Sormus, Helju, *Petersburg*
Spaar, Albert Peter Jr, *Charlottesville*
Stafford, Aubrey L, *Troutville*
Stage, Thomas B, *Vienna*
Stage, William Syms, *Alexandria*
Stewart, Allan H, *Fairfax Station*
Stewart, Colston Russell III, *Newport News*
Stewart, Lever F, *Charlottesville*
Steyn, Rolf W, *Annandale*
Straw, Gregory Martin, *Alexandria*
Sutton, Richard George, *Manassas*
Switzer, Robert Edward, *Dunn Loring*
Thomas, G June, *Manakin Sabot*
Thorpe, James J, *Alexandria*
Titus, Charles Cameron, *Reston*
Tomasulo, Richard Albert, *Charlottesville*
Toor, Svinder S, *Norfolk*
Troiano, Raymond G, *Virginia Beach*
Tsai, Shiko, *Alexandria*
Tucker, Weir M, *Richmond*
Urbach, John Richard, *Richmond*
Van Bavel, James Olaf, *Hampton*
Volkan, Vamik, *Charlottesville*
Wangler, John G Jr, *Waynesboro*
Weber, David J, *Richmond*
Weickhardt, George D, *Alexandria*
Winston, Bob, *Falls Church*
Woodward, Doris J, *Broadway*
Yavit, Joseph, *Annandale*
Yillar, Mehmet K, *Hampton*
Young, William Frederick, *Midlothian*
Zfass, Isadore Samuel, *Richmond*

Psychoanalysis

Johnston, Elizabeth W, *McLean*
Kiessling, Alice H, *Falls Church*
Kledzik, Ronald Bruce, *Virginia Beach*
Mc Donough, William Wallace, *Richmond*
Sebastian, Joseph A, *Falls Church*
Weinshank, Herbert S, *Fairfax*

Public Health

Agate, George H, *Highland Springs*
Allan, Susan M, *Arlington*
Bell, Gordon D, *Williamsburg*
Brown, Edwin Merriman, *Richmond*
Brown, Patricia Hoilman, *Richmond*
Cardona, Angel A, *Alexandria*
Clements, Francis J, *Yorktown*
Contis, George Peter, *Arlington*
Cope, William H, *Williamsburg*
Copley, Genrose Desimone, *McLean*
Crawford, William B Jr, *Merry Point*
Cunningham, James K, *White Stone*
Einarson, John, *Broad Run*
Fagan, Esther G, *Roanoke*
Fears, Belle De Cormis, *Accomac*
Graham, Samuel A, *Powhatan*
Hamner, John D Jr, *Ashland*
Harris, Joanna H, *Lynchburg*
Helm, Deborah L, *Hampton*
Hibben, Herbert A, *Sterling*
Hogg, Carol Ann, *Hampton*
Honeycutt, Grover C Jr, *Gate City*
Ingram, Ernagene F, *Wise*
Johnson, Richard Bailey, *Arlington*
Le Garde, Rector S, *Orange*
Linyear, Alice Strozik, *Richmond*
Long, Mary Tom, *Blacksburg*
Lovell, Charles F Jr, *Norfolk*
Morris, Laura G, *Norfolk*
Newby, Venita Carol, *Norfolk*
Newdorp, John, *Oakton*
Obenschain, Margaret B, *Roanoke*
Olsson, Shirley Anne C, *West Point*
Owens, Joanna M, *Mechanicsville*
Parmenter, Robert Earl, *Cumberland*
Passmore, Mildred R, *Roanoke*
Price, Robert Lee, *Richmond*
Richards, William D, *Madison Heights*
Root, Carl Frederick, *Radford*
Scheele, Andrew F, *Manassas*
Schwartz, Raymond L, *Falls Church*
Shanholtz, Mack Irvin, *Richmond*
Spencer, Frederick J, *Ruther Glen*
Stirewalt, John Miles, *Waynesboro*
Stroube, Robert Bruce, *Quinton*
Tenney, Malcolm Jr, *Staunton*
Thorpe, Curtis W, *Richmond*
Wagner, William Philip, *Richmond*
Wise, H S, *Norfolk*

Pulmonary Diseases

Apperson, William Eugene, *Richmond*
Arora, Narinder S, *Charlottesville*
Bailie, Allston Gibbes, *Richmond*
Baker, James Porter, *Norfolk*
Barrett, Francis E, *Richmond*

Pulmonary Diseases *(cont'd)*

Bazaco, George Constantine, *Oakton*
Betts, Martin Frederick, *Richmond*
Blackman, Raymond S, *Charlottesville*
Brunk, James Robert, *Harrisonburg*
Buhain, Wilfrido J, *Alexandria*
Buis, L James, *Richmond*
Burke, George Wilson III, *Richmond*
Chomicki, Joseph, *Roanoke*
Cooper, William Robert, *Virginia Beach*
Derring, Eldridge H Jr, *Norfolk*
Dicicco, Barry S, *Fairfax*
Fairly, John L Jr, *Richmond*
Freeman, Eric J, *Chesapeake*
Fusco, Frank Daniel, *Fairfax*
Grand, Bernard, *Alexandria*
Grinnan, Richardson, *Richmond*
Hamrick, Richard M III, *Richmond*
Heatwole, Kenneth M, *Charlottesville*
Hippensteel, Kirk E, *Roanoke*
Hunnicutt, Thomas N, *Newport News*
Jones, Robert Archer G, *Irvington*
Karpick, Ronald John, *Falls Church*
Kaufman, Steven H, *Norfolk*
Keeley, Robert C, *Roanoke*
Kim, Taik Chae, *Charlottesville*
Lewis, B Franklin, *Winchester*
Lightburn, Alize Cole, *Rochelle*
Longo, Antonio Miguel, *Alexandria*
Mann, James Packard, *Dumfries*
Mathers, James A L Jr, *Richmond*
Matsushige, Kouichi, *Portsmouth*
Maxey, Ellis Franklin Jr, *Chesapeake*
Mc Brayer, Reuben H Jr, *Norfolk*
Mc Gehee, Read F Jr, *Richmond*
Milam, Michael G, *Lynchburg*
Morley, John Wilson, *Richmond*
Oast, Fred F, *Roanoke*
Onder, Mehmet Hami, *Fairfax*
O'Neill, Thomas J, *Danville*
Prince, John Martin Jr, *Norton*
Quate, Larry J, *Chesapeake*
Radow, Scott K, *Richmond*
Ray, Edward Scott, *Richmond*
Roberts, Bruce T, *Richmond*
Rochester, Dudley F, *Charlottesville*
Santos, Rolando J, *Springfield*
Sappington, Richard F Jr, *Alexandria*
Scutero, James Vincent, *Chesapeake*
Smith, Rodney Hall, *Richmond*
Spaur, William Hamilton, *Chesapeake*
Stewart, Bruce Neal, *Roanoke*
Termini, John Edward, *Mc Lean*
Thompson, James A III, *Richmond*
Trainor, William D, *Alexandria*
Weber, Charles Alfred, *Springfield*
White, John James, *Blacksburg*
Wigton, Roger B, *Alexandria*
Witten, James A, *Salem*

Radiology

Abbitt, Patricia Lipford, *Charlottesville*
Alavi, S Manucher, *Richmond*
Ali, Mohammed M, *Midlothian*
Allen, Anton Markert Jr, *Clifton Forge*
Allen, Donald Miller, *Fredericksburg*
Allen, Edward G, *Clifton Forge*
Allen, Robert Monteith, *Falls Church*
Ammann, Albert M, *Newport News*
Amory, Harold I, *Hampton*
Austin, Charles N, *Abingdon*
Badin, Nicholas III, *Petersburg*
Baggerly, John Thomas Jr, *Danville*
Baldo, Edna Reyes, *Burke*
Barnard, John William, *Salem*
Barr, William Clayton, *Richmond*
Barrow, Frederick P II, *Virginia Beach*
Bartok, Stephen Paul, *Gloucester Point*
Bartol, Dennie Thomasson, *Williamsburg*
Bassham, Harold Lee, *Abingdon*
Bentley, Jack Kitchener, *Richmond*
Beskin, Robert Rekedal, *Charlottesville*
Bezirdjian, Diran R, *Richmond*
Bisaccia, Leonard Joseph, *Springfield*
Blackwell, James Edward, *Roanoke*
Bowen, Bruce James, *Falls Church*
Bozman, Raymond Elwood, *Chesapeake*
Brallier, David Ronald, *Fairfax*
Braun, Ira Franklin, *Richmond*
Bray, Stuart Thomas, *White Stone*
Bredrup, Ole C Jr, *Richmond*
Brenbridge, A Norman A G, *Charlottesville*
Brendlinger, Dirck L, *Richmond*
Brock, Jack Gilbert Jr, *Galax*
Brody, Jeffrey Morris, *Arlington*
Buatti, John Michael, *Warrenton*
Bundrick, Thomas John, *Bridgewater*
Bundschuh, Carl V, *Norfolk*
Burwell, James Abraham, *Falls Church*
Buschi, Anthony J, *Charlottesville*
Calkins, Ronald Fleming, *Richmond*
Callahan, Donald Morris, *Harrisonburg*
Campbell, James Ashton, *Richmond*
Campbell, Joseph Cameron, *Martinsville*
Canter, Noland M Jr, *Harrisonburg*
Carmichael, Pauline D, *Salem*
Carr, John Donald, *Newport News*
Carr, Stephen Lafayette, *Charlottesville*
Cassada, William Abraham, *Salem*
Chambers, Donald Edwin, *Norfolk*
Chason, David Paul, *Charlottesville*
Cho, Shao-Ru, *Richmond*
Choi, Walter Sik, *Alexandria*
Chucker, George N, *Clifton Forge*
Chun, Hachong, *Richmond*
Chung, Doo Hyoun, *Vienna*
Clore, Jesse Newton Jr, *Winchester*
Coburn, Ernest L Jr, *Tazewell*
Collier, Annamarie Reddin, *Winchester*
Conca, Dominick Michael, *Staunton*
Conway, William Feil, *Richmond*
Cooney, Dorothy F, *Farmville*
Cooper, George Jr, *Charlottesville*
Cornell, Roger Detlef, *Clifton*
Cosgrove, William J, *Falls Church*
Cramer, Mark S, *Norfolk*
Crawford, William Osgood Jr, *Vienna*
Crimone, Samuel M, *Arlington*
Cunningham, Dorris A, *Abingdon*
Cuong, Tran Trong, *Alexandria*
Daughdrille, John Ernest, *Richmond*
Daugherty, Micki Jacks, *Front Royal*
Davidoff, Alan Brett, *Vienna*
Davis, James Karnes, *Newport News*
Dawson, Elizabeth Adams, *Petersburg*
Debbas, Maureen S, *Alexandria*
Dee, Paul Michael, *Charlottesville*
Degrazia, John B, *Arlington*
De Guzman, Placido H, *Salem*
De La Torre, Ricardo, *Virginia Beach*
Delange, Eduard Ellis, *Charlottesville*
Deponte, Kathleen Ann, *Norton*
Deyton, Walter Edward, *Danville*
Dillard, Powell G Jr, *Lynchburg*
Dina, Thomas Stewart, *Vienna*
Doshi, Ramesh D, *Roanoke*
Dufour, Jean Maurice, *Richmond*
Dunn, Miroslawa Makowicz, *Yorktown*
Eckard, Donald Alan, *Charlottesville*
Ehrenworth, Adolphe M, *Petersburg*
Eichler, Thomas James, *Richmond*
Ekey, David Price, *Richmond*
Erdman, Robert L, *Nassawadox*
Erim, Zeki, *Springfield*
Eryilmaz, Nurettin, *Richlands*
Fant, Palmer Willis, *Independence*
Faris, Marion D, *Alexandria*
Farrar, Howard Ashby, *Newport News*
Faunce, Howard F, *Richmond*
Ferguson, Robert Donald, *North Garden*
Ferris, Robert Allen, *Burke*
Fields, William Russell, *Richmond*
Finch, Robert Delmar, *Collinsville*
Finestone, Alvin William, *Clifton Forge*
Fitch, Willard M, *Midlothian*
Floyd, Harold Leopold, *Richmond*
Ford, Kiah Thornton III, *Lynchburg*
Fowler, Daniel Troy, *Tazewell*
Fratkin, Melvin Joel, *Richmond*
Frierson, John Hugh Jr, *Midlothian*
Fu, Whei-Rung, *McLean*
Galal, Fathy S, *Arlington*
Galbo, Claudia Emmert, *Vienna*
Galston, Herbert Harold, *Richmond*
Gandee, R Wayne, *Roanoke*
Garcia, Robert C, *Falls Church*
Garciala-Jacomino, Jorge Modesto, *Arlington*
Garrison, Joseph Shermer III, *Newport News*
Gay, Spencer Bradley, *Earlysville*
Gearing, Frank W Jr, *Harrisonburg*
Gildersleeve, Gerald A, *Winchester*
Glass, Ted Alan, *Fredericksburg*
Goodman, Stephen Joel, *Fairfax*
Goodwin, Lyndon Keith, *Fairfax*
Gordon, Gary Hart, *Alexandria*
Grantham, Don Earl, *Newport News*
Grayson, Jane, *McLean*
Green, Robert, *Lynchburg*
Hagen, Harold M, *Manassas*
Hager, Harry G Jr, *Williamsburg*
Hakkal, Halappa G, *McLean*
Hall, Tom Edward, *Painter*
Hanson, Irvin Rivers Jr, *Alexandria*
Hanson, Kirsten Ann, *McLean*
Hargroves, Andrew W Jr, *Virginia Beach*
Harsanyi, Paul Gabor, *Vienna*
Harshaw, William George Jr, *Falls Church*
Harvey, Arthur James, *Norfolk*
Hauser, J Bruce, *Roanoke*
Hawkins, Richard F Jr, *Marion*
Hayes, Curtis Woods, *Midlothian*

Radiology *(cont'd)*

Hellems, Harper Keith Jr, *Warrenton*
Henderson, Charles Henry, *Harrisonburg*
Henry, Daniel Anthony, *Midlothian*
Henwood, Wesley Charles, *Hot Springs*
Herring, Russell E Jr, *Crozet*
Holland, Nancy Darden, *Galax*
Holmes, Francis Hammond, *Portsmouth*
Holmes, I Earl, *Colonial Beach*
Holmes, William Sanner, *Charlottesville*
Howell, Talmadge Rudolph, *Chester*
Hudson, Thomas David, *Fairfax*
Hurwitz, Julius, *Richmond*
Jackson, Reginald C, *Richmond*
Jacobs, Eugene R, *Arlington*
Jamarik, George Thomas, *Leesburg*
Jamison, Thomas M, *Williamsburg*
Janus, Cynthia L, *Charlottesville*
Jelinek, James Stephen, *McLean*
Jenkins, Donald W, *Charlottesville*
Jolles, Howard, *Richmond*
Jonakin, Steven Kenneth, *Pulaski*
Kakria, Ramesh C, *Virginia Beach*
Kendall, Mark A, *Williamsburg*
Kenneweg, Donald John, *Fredericksburg*
Kesler, Robert Milton, *Norfolk*
Kidder, Robert Edward, *Richmond*
Kim, Jung-Ah C, *Charlottesville*
King, Donald Perry, *Richmond*
King, George Chen, *Midlothian*
Kirschner, Louis Paul, *Vienna*
Klein, Jeffrey Allen, *Norfolk*
Knight, Morris Reed Jr, *Virginia Beach*
Koutrouvelis, Panos G, *Falls Church*
Kuehn, Hubert Walter, *Chesapeake*
Kurzbard, Stephen Jay, *Arlington*
Lader, Clifford David, *Fairfax*
Lagundino, Flordelino C, *Tappahannock*
Landey, Herbert Max Jr, *Roanoke*
Lederman, Carl S, *Alexandria*
Legg, Quentin J, *Newport News*
Leslie, Paul Albert, *Arlington*
Lester, Richard G, *Norfolk*
Lewis, Terry Dennis, *Richmond*
Lichtenstein, Gary B, *South Boston*
Lipman, Ansel, *Portsmouth*
Lipper, Maurice H, *Charlottesville*
Liu, Chung-I, *Midlothian*
Lloyd, Clyde Franklin, *Salem*
Lo, Hing-Har, *Blacksburg*
Loiacono, Patsy Julius, *Grafton*
Ly, Hoa Hong, *Fairfax*
Lynde, James L, *Lynchburg*
Mahadevan, Harihara I, *Hampton*
Mahan, Jack Delano, *Norfolk*
Mahon, Charles B, *Williamsburg*
Man, Philip Shu-Hoi, *McLean*
Manetz, Charles E, *Midlothian*
Mapp, John R, *Nassawadox*
Marsteller, Luisa Portal, *Newport News*
Martin, John Albert, *Roanoke*
Martin, Lewis K II, *Winchester*
Mascatello, Vincent J, *Reston*
Maslar, Judith Ann, *Arlington*
Maso, Eugene C, *Springfield*
Massey, Philip N, *Manassas*
Mathis, John Milligan, *Salem*
Mayer, Andrew A, *Norfolk*
Mayson, Preston B Jr, *Roanoke*
Mc Cabe, Dennis J, *Vienna*
Mc Cabe, Joseph G, *Winchester*
Mc Clane, John R, *Wytheville*
Mc Cluney, K W, *Roanoke*
Mc Clure, Phillip H, *Petersburg*
Mc Ilhenny, Joan, *Trevilians*
Mc Williams, Thomas G, *Arlington*
Mertens, Michael A, *McLean*
Messmer, James Michael, *Richmond*
Miller, Richard H, *Virginia Beach*
Mills, Steven Robert, *Fairfax Station*
Morehouse, I Roger, *Radford*
Morris, Judah L, *Charlottesville*
Moser, Edgar Strock Jr, *Richmond*
Mullet, James G, *Roanoke*
Mullins, Maurice Francis, *Richmond*
Murphy, Cornelius Francis, *Alexandria*
Murray, Robert Louis, *Roanoke*
Narla, Lakshmana Das, *Richmond*
Navani, Shiv, *Big Stone Gap*
Nelson, Martha Wells, *Great Falls*
Newmark, Bertram J, *Blacksburg*
Nold, Ralph John, *Suffolk*
O'Connell, Robert Stephen, *Fairfax*
Olson, John Robert Jr, *Franklin*
Otte, Ray Charles, *Hampton*
Outten, Sharon Jennings, *Farmville*
Overcash, William E, *Danville*
Owens, Harold B, *Danville*
Padgett, Thomas E, *Portsmouth*
Painter, William E, *Lynchburg*
Patel, Bharat R, *Radford*
Patel, Dilip B, *Richlands*
Patel, Dilipkumar Ratilal, *Richlands*
Patel, Jashbhai Nathabhai, *Grundy*
Patterson, Abram M Jr, *Roanoke*
Pearce, Carney C Jr, *Petersburg*
Penniston, Lawrence W, *Suffolk*
Pischnotte, William Otto, *Portsmouth*
Pogonowska, Magdalena J, *Blacksburg*
Powers, Paxton P, *Staunton*
Prasad, Uma Rajendra, *Richmond*
Presberg, Harry Joe, *Norfolk*
Price, Charles W, *Salem*
Prominski, John E, *Falls Church*
Ram, Panol Chir, *Woodbridge*
Rao, Kishore G, *Hampton*
Ratliff, John M Jr, *Newport News*
Read, Marc Edward, *Woodstock*
Reddy, Cheepuloti H, *Clifton Forge*
Redmond, James Seymour, *Lynchburg*
Reese, Mitchell S, *Richmond*
Rice, James Davies, *Roanoke*
Richard, Louis E, *Petersburg*
Rieth, Kenneth G, *Falls Church*
Rigsby, Christopher Mark, *Fairfax*
Roberts, Bobbie Lee, *Richmond*
Robins, Jerrold Reid, *Rosslyn*
Rohrer, Dennis G, *Harrisonburg*
Rosenthal, Sheldon Jay, *Springfield*
Rowland, Robert C Jr, *Chesapeake*
Rubis, Paul John, *Richmond*
Russell, Carl M, *Roanoke*
Ryplansky, Anatol, *Dublin*
Saha, Subhash C, *Big Stone Gap*
Sanderson, Jesse F Jr, *Newport News*
Savage, Bernard M, *Richmond*
Sawyer, Rae W, *Kilmarnock*
Scatarige, John Charles, *Norfolk*
Schaner, Everett G Jr, *Falls Church*
Seim, Donald Edward, *Virginia Beach*
Sforza, Peter Patrick, *Roanoke*
Shapiro, Joel Hirsch, *Wirtz*
Sharma, Ashok K, *Falls Church*
Sheely, William Edward, *Falls Church*
Shivel, Glen L, *Richmond*
Showalter, Henry Bernard Jr, *Richmond*
Siddiky, Muhammad Ali, *Norfolk*
Sikes, Randall Arthur, *Newport News*
Smith, Bernard F, *McLean*
Snead, James Given, *Roanoke*
Snead, Lawrence O Jr, *Richmond*
Solack, George Andrew, *McLean*
Spencer, Henry S, *Mechanicsville*
Stanley, Dennis C, *South Boston*
Stanton, Larry Wayne, *Fairfax*
Stitik, Frederick Paul, *Virginia Beach*
Stoecker, Thomas J, *Roanoke*
Stokes, Kenneth R, *Virginia Beach*
Tagliabue, James Robert, *Alexandria*
Talley, Daniel Doak III, *Richmond*
Talley, Lilburn Trigg, *Winchester*
Tamminen, John Lucky Hendric III, *Blacksburg*
Tan, Domingo Chiong, *Chesapeake*
Tatum, James L, *Richmond*
Tercilla, Oscar Felipe, *Midlothian*
Thiele, Arthur L, *Charlottesville*
Thomas, Bruce Richard, *Roanoke*
Thomas, William Nathaniel Jr, *McLean*
Thurman, W Allen Jr, *Midlothian*
Tisnado, Jaime, *Richmond*
Toxopeus, Margaret E, *Winchester*
Turner, Lewis John Jr, *Warrenton*
Vadney, Richard Claude, *Arlington*
Van Breda, Arina, *Alexandria*
Vinik, Melvin, *Manakin-Sabot*
Wadsworth, James D, *Petersburg*
Wagner, Archibald C, *Warrenton*
Walch, Francis R, *Winchester*
Walker, Harold Stanley, *Alexandria*
Wallace, K K, *Norfolk*
Walsh, James W, *Richmond*
Washburn, Ronald Lee, *Virginia Beach*
Wendell, John M Jr, *Newport News*
Wheeler, William Edge, *Richmond*
Whitley, Donald Phillip, *Richmond*
Winkler, Charles P, *Richmond*
Wladyka, George Andrew, *Falls Church*
Wolfe, Walter W Jr, *Lebanon*
Wood, Henry Wise Jr, *Norfolk*
Wood, John Lawrence, *Winchester*
Wood, William Alexander Jr, *Williamsburg*
Woodward, Denton Dick, *Chesapeake*
Woolfitt, Robert A, *Norfolk*
Worthington, Janette L, *Richmond*
Yama, George H, *Pulaski*
Yoo, Hyung Ryong, *Vienna*
Yount, B Gerald Jr, *Richmond*
Zasada, Andrew Peter, *Chesapeake*
Zelenik, Mary Ella, *Salem*
Ziegler, Herman Frederick, *Wytheville*

Rheumatology

Bacon, Anne M, *Winchester*
Blaylock, William M, *Salem*
Cooke, Charles Lee, *Richmond*
Davis, John Staige IV, *Charlottesville*
Dunnington, Arthur R, *Virginia Beach*
Farley, Emerson D Jr, *Richmond*
Giuliano, Vincent Joseph Jr, *Charlottesville*
Gough, William Wood, *Norfolk*
Gray, Pamela, *Norfolk*
Irby, W Robert, *Richmond*
Koller, Stephen Rice, *Richmond*
Maxwell, David Baldwin, *Newport News*
Nguyen, Long Thanh, *Falls Church*
O'Brien, William Michael, *Charlottesville*
Oliver, Cap H Jr, *Arlington*
Owen, Duncan Shaw Jr, *Richmond*
Reed, William W, *Norfolk*
Toone, Elam Cooksey Jr, *Richmond*
Wallingford, Walter R, *Hampton*
Welton, Richard C, *Newport News*
Wilson, Jeffrey W, *Lynchburg*

Thoracic Surgery

Azar, Hormoz, *Norfolk*
Baker, Lenox Dial Jr, *Norfolk*
Bas, Mauricio D Jr, *Woodbridge*
Bergen, Frederick, *Petersburg*
Bogaev, Leonard R, *Mathews*
Bosher, Lewis Hinton Jr, *Richmond*
Broaddus, Carl A Jr, *Irvington*
Brooks, James W, *Richmond*
Burton, Nelson Avard, *Annandale*
Byrne, William Draper, *Annandale*
Calhoun, Daniel M Jr, *Newport News*
Chai, Hyoun Chul, *Hampton*
Cian, Louis George, *Franktown*
Daniel, Thomas Moore, *Charlottesville*
Deignan, Joseph Michael Jr, *Winchester*
Edrington, Richard D, *Fredericksburg*
Goff, Rowland D Jr, *Winchester*
Gonzalez, Miguel H, *Alexandria*
Hanash, Kamal Antoine, *McLean*
Harpole, David H, *Roanoke*
Hotchkiss, William S, *Virginia Beach*
Katz, Paul Gary, *Richmond*
Keeley, Robert L, *Roanoke*
Kistler, Philip Crosby, *Roanoke*
Kron, Irving Louis, *Charlottesville*
Lanyi, Thomas Richard, *Richmond*
Lee, Chong Wook, *Alexandria*
Lefrak, Edward Arthur, *Annandale*
Lower, Richard Rowland, *Richmond*
Mc Daniel, Samuel M, *Norfolk*
Minor, George Ridgway, *Charlottesville*
Muller, William H Jr, *Charlottesville*
Peterson, Noel Rae, *Chesapeake*
Reines, Howard David, *Richmond*
Robertson, William A, *Richmond*
Sadjadi, Parviz-Mohsen, *Clifton Forge*
Salzberg, Arnold M, *Richmond*
Sihelnik, Stephen Adam, *Vienna*
Strayhorn, Earl C, *Norfolk*
Szentpetery, Szabolcs, *Richmond*
Tenekjian, Vasken Kevork, *Portsmouth*
Tucker, Ashley R III, *Winchester*
Zimberg, Yale H, *Richmond*

Traumatic Surgery

Kiernan, Paul D, *Annandale*

Urological Surgery

Abramson, Edward Gerald, *Alexandria*
Allen, John Thomas, *Roanoke*
Alperstein, Joel Barry, *Alexandria*
Altaffer, Lawrence F III, *Fredericksburg*
Alvir, Rene B, *Arlington*
Andrews, Michael J Jr, *Danville*
Arnold, Fredrick S, *Gloucester*
Arnold, Janice Lee, *Oakton*
Assadnia, Assadolah, *Franklin*
Atwill, William Henry, *Richmond*
Bagley, Clifford E, *Nokesville*
Bailey, Gary Alan, *Harrisonburg*
Baldwin, Monroe Glass Jr, *Lynchburg*
Banks, Marshall D, *Richmond*
Basso, Alessandro G, *Winchester*
Bates, Robley D III, *Richmond*
Bayne, David P, *Hampton*
Beall, Michael Edgar, *Vienna*
Beamon, Charles Ralph Jr, *Fredericksburg*
Beazlie, Frank S Jr, *Newport News*
Benson, Mark Alan, *Clarksville*
Berger, Myron Paul, *Annandale*
Berger, Robert M, *Burke*
Bergman, Stuart M, *Martinsville*
Bigley, H Alan Jr, *Petersburg*
Bilowus, Mark L, *Reston*
Binard, Joseph E, *Fairfax*
Bobbitt, John M, *Newport News*
Boone, Elwood Bernard Jr, *Richmond*
Borges, Philip M, *Falls Church*
Boutros, Samir B G, *South Hill*
Buck, Frank Neville Jr, *Lynchburg*
Burger, Robert Henry, *Norfolk*
Butler, W W Sam IV, *Roanoke*
Butler, William W III, *Roanoke*
Byrne, Robert E, *McLean*
Carey, Peter Oxenham, *Charlottesville*
Carroll, Patrick Anthony, *Vienna*
Castleberry, Gordon M, *Farmville*
Chavez, Rolando M, *Cedar Bluff*
Chenault, Oran Ward Jr, *Chesapeake*
Clark, John Robert Jr, *Martinsville*
Clark, William Edwin Jr, *Roanoke*
Clower, Dean, *Lynchburg*
Cobbs, Wilson N, *Norfolk*
Concodora, Joseph A, *Hopewell*
Cote, Eric Paul, *Richmond*
Councill, Wilford A Jr, *Gloucester*
Datta, N C, *Warrenton*
Davis, Charles S Jr, *Virginia Beach*
Deans, Robert Douglas, *Blacksburg*
Decker, Sterling R, *Virginia Beach*
Devine, Charles Joseph Jr, *Norfolk*
Devine, Patrick Campbell, *Norfolk*
Di Sandro, Giovanni, *Fairfax*
Dodson, Austin I Jr, *Richmond*
Dougherty, William E, *Arlington*
Downing, Sam W, *Alexandria*
Drew, J Edwin, *McLean*
Drucker, Jacob R, *Norfolk*
Duck, George B, *Richmond*
Duruman, Nevzat, *Danville*
Dyer, Robert K, *Miles*
Elkins, Irving Barefoot, *Radford*
Etheridge, James Craig, *Richmond*
Fanous, Hafez N, *Alexandria*
Fauver, Howard Earl Jr, *Fairfax*
Fehrenbaker, Lawrence, *Danville*
Feminella, John George Jr, *Petersburg*
Ferguson, W Joseph, *South Boston*
Finnerty, Paul Edward, *Arlington*
Fiveash, Joseph G Jr, *Virginia Beach*
Fletcher, Alan, *Hampton*
Fraker, Robert T, *Midlothian*
Frederick, Louis Arnold, *Richmond*
Gallo, David Alexander, *Norfolk*
Gehrken, George A Jr, *Martinsville*
Gibas, Dinos, *Radford*
Gil Montero, Guillermo H, *Manassas*
Gillenwater, Jay Young, *Charlottesville*
Gilmontero, Guillermo H, *Manassas*
Glover, William Lloyd Jr, *Fairfax*
Gnanasekaram, Ganesan Sanmugam, *Norfolk*
Gonzales, Jose E, *Norfolk*
Graham, Christopher Walker, *Arlington*
Graham, Richard W, *Richmond*
Graham, Sam D, *Staunton*
Gray, F Bradley, *Fredericksburg*
Gronkiewicz, Bruce Vincent, *Virginia Beach*
Guice, John Madsion, *Richmond*
Guirguis, Abel B, *Winchester*
Hackler, Robert H, *Richmond*
Hardy, Michael R, *Fairfax Station*
Harrell, Robert Riddick, *Suffolk*
Harris, David Lea, *Kilmarnock*
Hart, John M, *Galax*
Herrera, Hector Hernando, *Falls Church*
Hill, John Edward, *Richmond*
Hillyard, Raymond Wesley Jr, *Winchester*
Hoffman, Allan A Jr, *Danville*
Hollowell, John W, *Portsmouth*
Holmes, Bert W Jr, *Norfolk*
Howards, Stuart S, *Charlottesville*
Hurt, G Samuel, *Martinsville*
Imbur, Donald J, *Virginia Beach*
Jenkins, Alan D, *Charlottesville*
Johnson, Mark L, *Portsmouth*
Jones, Jeffrey Stephen, *Salem*
Jones, William Russell Jr, *Richmond*
Jordan, Gerald H, *Norfolk*
Kadakkal, Ramesh B, *Virginia Beach*
Kasenetz, Iver, *Falls Church*
Katz, Stuart Eric, *Springfield*
Kelly, Timothy L Jr, *Arlington*
Khatib-Shahidi, Mani, *Vienna*
Khawand, Nabil Youssef, *Arlington*
King, William Whitman, *Radford*
Klapproth, Hans Joachim, *Annandale*
Klousia, John Walter, *Alexandria*
Kodama, Ronald Takashi, *Virginia Beach*
Koontz, Warren Woodson, *Richmond*
Koziol, Isaac, *Richmond*
Kramolowsky, Eugene V, *Richmond*
Landes, Ralph Roy, *Danville*
Laurent, A Daniel, *Reston*
Lebowitz, J Martin, *McLean*

Urological Surgery *(cont'd)*

Leffke, David William, *Lynchburg*
Link, Garnett William, *Petersburg*
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VIRGINIA MEDICAL

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Recent recommendations from our committee include premium discounts for physicians recertified in their specialty; the review by legal counsel of a birth control device release form being distributed by a manufacturer; that TVIR staff prepare a detailed proposal on a change to enhance tail coverage for retiring physicians. All of these recommendations were developed from the regular contributions of working physicians who have first-hand experience with the day-to-day operations of current practice.

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—Sandra L. Kramer, MSV Counsel

The Medical Society of Virginia has not taken an official position with respect to risk retention groups. Whether or not to participate in such a group is an individual determination. The information provided is intended simply as background information to assist you with your individual analysis; it is not intended, and should not be used, as a substitute for consultation with legal counsel.

LETTERS

Long-time nursing school teacher favors both diploma, degree programs

I certainly agree with Dr. Hotchkiss' Point of View article in the May issue of Virginia Medical.[1] Specifically, I agree that the registered care technologist (RCT) program is worth trying out until permanent solutions can be found.

Having taught for over 40 years in the St. Luke's School of Nursing in Richmond, I have a feeling that hospital-trained nurses are superior to the degree nurse, at least in looking after patients. I have also observed that the diploma nurse with additional specialized training can take her place with the degree nurse in complicated high tech programs, from emergency rooms to coronary and critical care units.

As you well know, 75% of the nurses in this country have been trained in hospital or diploma programs. There is no way university degree programs can turn out the volume of nurses needed to relieve the current shortage. Moreover, not all young women who want to be nurses want, or can afford, a college education, but that does not preclude their making good nurses.

St. Luke's, the oldest school of nursing south of the Mason-Dixon Line, turned out about 906 fine nurses over its 100-year history before the Humana Corporation closed it in 1886. One of its most illustrious graduates, Class of 1889, became superintendent of nurses at St. Luke's Hospital, then, in 1904, went to the University of Minnesota, where in 1909 she and Dr. Beard established the first school of nursing in the United States leading to the bachelor of science degree of nursing.

I think we need both diploma and degree programs, and also LPNs. Programs for the latter, I understand, have been discontinued in some areas at this critical time when we need more nurses.

John P. Lynch, MD

118 Paxton Road
Richmond VA 23226

1. Hotchkiss WS. Nursing shortage: "The key is to move ahead." Va Med 1989;116:229–230

Cites role of psychiatrists in impaired physicians program

I would like to congratulate Dr. David Fluharty's work as described in "Portrait of an Impaired Physician"[1] in helping to address the impaired physician. I did take issue with one comment in the article that described the actual treatment of a typical patient, named

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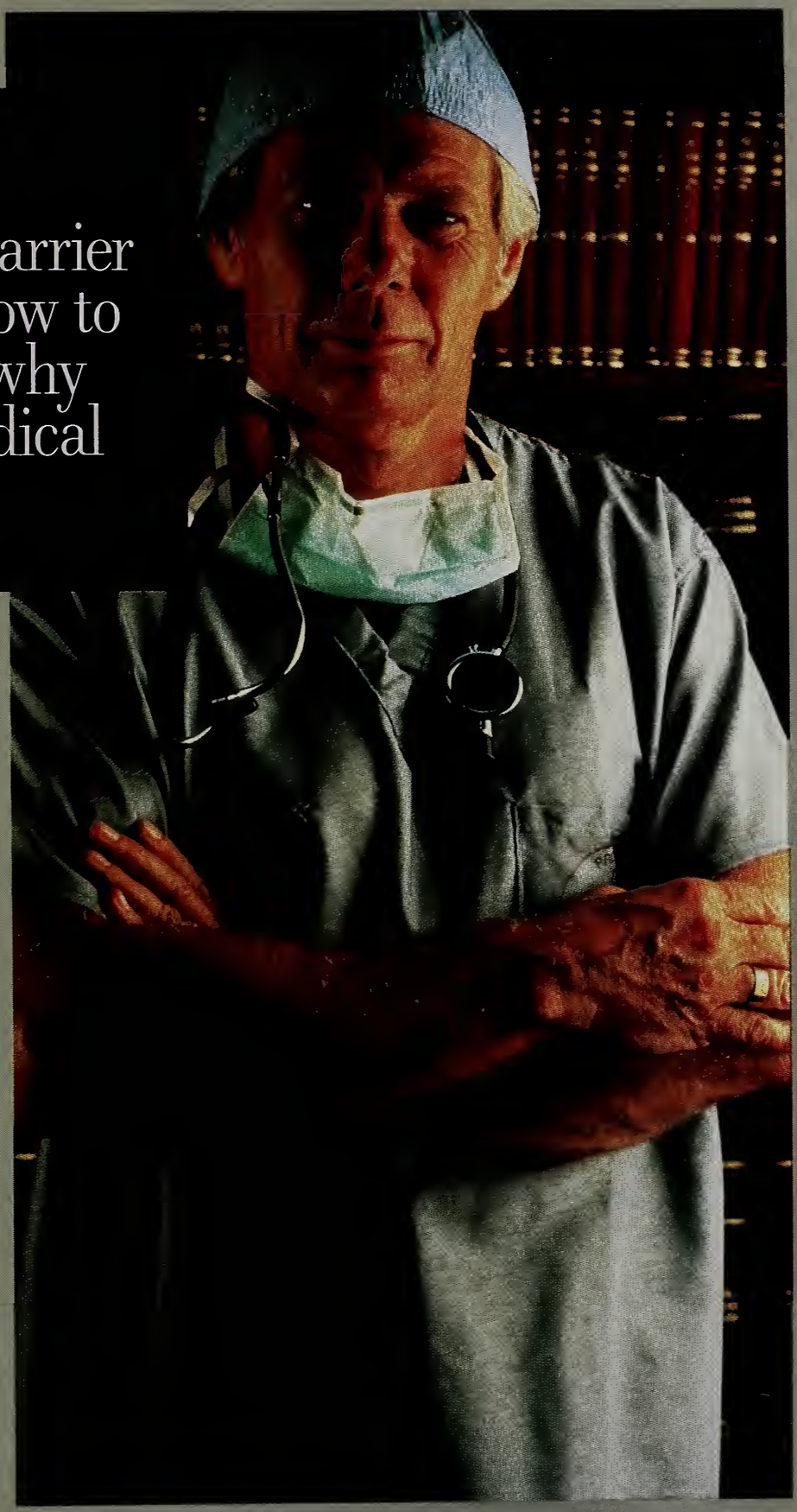

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"John", who was "evaluated both physically and emotionally by a psychologist." Psychiatrists are the only mental health professionals qualified to diagnose and evaluate both physically and emotionally. It is important for psychiatrists to be involved and, in particular, to look at the differential diagnosis because when dealing with alcoholism, very often there are other emotional disorders, such as depression, in process as well.

It has been my observation that some physicians seek treatment from psychologists and other mental health professionals as a way of avoiding coming to grips with their problems, since they feel they are less likely to be found out. They are able to retain their air of superiority since they are doctors and are fearful of facing a peer physician, a psychiatrist, straight in the eyes. When one of ours is injured, I believe we are obligated to have them treated by the most qualified healer, a fellow physician and, in this case, a psychiatrist.

I do hope that this is the case and that we as psychiatrists have not fallen behind in supporting and treating impaired physicians. Quite frequently, physicians come to treatment outside the impaired physician program and are successfully restored to health in both their family and professional lives.

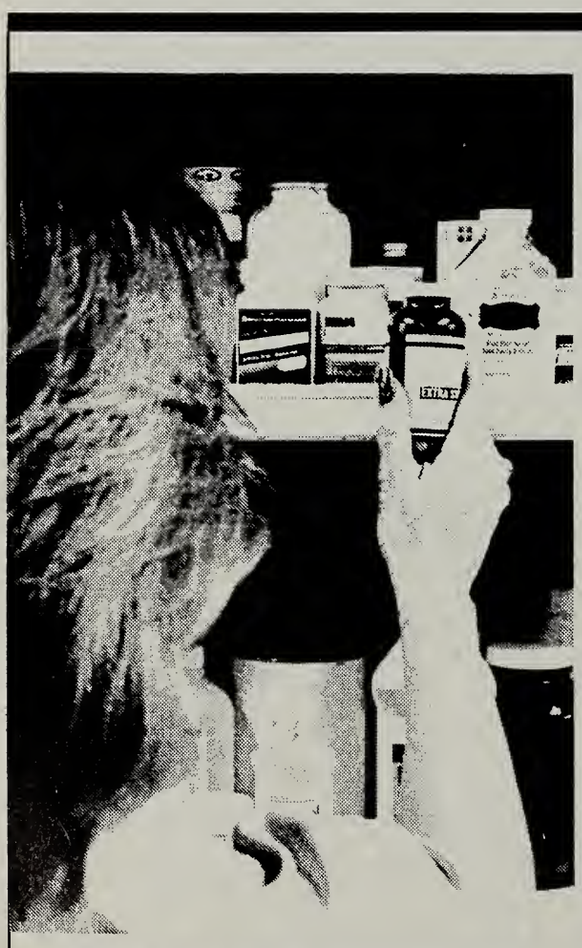
Blaise C. Scavullo, MD
7605 Forest Avenue, Suite 414
Richmond VA 23229

1. Fluharty DGjr. Portrait of an impaired physician. Va Med 1989; 116:266-269

Dr. Fluharty replies: The sentence in question was not meant to infer that a psychologist did a physical, but rather that John was evaluated by a multidiciplinary team both physically and emotionally. The team included a psychologist, a specialist in addictive diseases, and an internist. The internist, of course, did the physical. I thank Dr. Scavullo for the opportunity to clarify this fact.

Erratum

The Editors regret a misnomer in the May issue. Dr. Richard A. Szucs was the radiologist who contributed to the Grand Rounds on Takaysus' arteritis, not K. Souch, MD, as the original manuscript reported.



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VIRGINIA MEDICAL
AUGUST 1989

Evaluation and Treatment of the Hirsute Woman

John E. Nestler, MD, *Richmond, Virginia*

Hirsutism is a common disorder for which there are effective therapies. Its emotional effects are serious in nature, however, and should not be underestimated by the physician. The author discusses the pathophysiology of hirsutism, recommends appropriate diagnostic tests, and describes current treatment modalities.

The definition of hirsutism depends not only on the quantity and pattern of hair growth on a woman but also on racial, ethnic and cultural considerations. For example, Chinese or Scandinavian women are typically rather hairless, whereas women of Mediterranean descent (Italian, Spanish, Greek) commonly have demonstrable hair on the upper lip, arms and legs. In her own society an Italian woman perceives herself as normal, but if you transport her to a Scandinavian country she may well be regarded as hirsute.

In our own society the common perception is that women should be relatively hair-free. Nonetheless, a study by Edith McKnight of 400 consecutive young college women demonstrated that 26% of these women had thick and pigmented, or "terminal," hair on the face, 17% on the chest or breast, 35% on the lower abdomen, and 84% on the arms and legs.[1] (Soft, nonpigmented hair is called "vellus" hair.) Although these women were of Anglo-Saxon and Welsh origin, they probably reflect the actual pattern of hair distribution in women of our society as well.

From the Division of Endocrinology and Metabolism, Medical College of Virginia/Virginia Commonwealth University. Address correspondence to Dr. Nestler at Box 111, MCV Station, Richmond, VA 23298.

This work was supported in part by a feasibility grant from the American Diabetes Association and a small grants award from the Medical College of Virginia. Submitted 10-22-88.

Despite the vagaries of definition, the serious nature of hirsutism should not be underestimated. If a woman perceives herself as hirsute or is perceived as hirsute by her peers, she may feel socially ostracized and experience much unhappiness. Therefore, every effort should be made to ascertain the cause of hirsutism in a young woman so that appropriate therapy can be instituted.

Clinical Classification

Following a thorough history and physical examination, a hirsute woman can usually be assigned to one of three clinical catagories: 1) simple hirsutism with normal menses, 2) hirsutism with menstrual dysfunction (oligomenorrhea or amenorrhea), or 3) virilization. These distinctions are useful for the following reasons. Simple hirsutism is usually caused by nonmalignant androgenic overstimulation of the hair follicle. The evaluation required to define the etiology of the androgenic overstimulation is relatively simple and straightforward. However, if a woman has menstrual dysfunction accompanying her hirsutism, she needs to be evaluated for two endocrine disorders which may or may not be linked to one another: hirsutism and menstrual dysfunction. Finally, if a woman presents with symptoms or signs of virilization, the possibility of an ovarian or adrenal neoplasm must be entertained and an aggressive workup undertaken to exclude such

a diagnosis.

The clinical distinction between hirsutism and virilization is usually made on the following grounds. In simple hirsutism excessive hair growth may be present on the face, chest, breast, lower abdomen, arms or legs. However, it is distinctly unusual for excessive hair growth to occur over the shoulders or back.[1,2] Terminal hair growth at these two sites should be regarded as a sign of virilization. The normal size of the clitoris, when the vertical and horizontal dimensions are multiplied (termed the "clitoral index"), is ≤ 35 mm^2.[3] Clitoromegaly, commonly defined as a clitoral index ≥ 100 mm^2, is a sign of virilization. Other signs of virilization include frontal or temporal balding, deepening of the voice, and increased muscular development. Finally, simple hirsutism typically begins around the time of puberty and progresses slowly over several years. Any woman who presents with a history of recent or rapid progression of excess hair growth should be suspected of having an ovarian or adrenal neoplasm.

Pathophysiology

In order to properly evaluate a patient for hirsutism, one must understand the mechanisms which may lead to androgenic overstimulation of the hair follicle (Table 1). The ovaries are the most frequent site of excessive androgen production. Polycystic ovary syndrome (PCO) is the most common ovarian cause of hyperandrogenism. This syndrome, which remains relatively ill-defined,[4,5] typically presents with a long history of slowly progressive hirsutism, hyperandrogenism, oligo- or amenorrhea, infertility, an elevated luteinizing hormone (LH) to follicle-stimulating hormone (FSH) ratio, and bilaterally enlarged and cystic ovaries on ultrasonography. Although most women with PCO are obese, many are not. Controversy exists regarding the precise definition of PCO, and many women are classified as having PCO despite the absence of several of the above criteria. The pathogenisis of PCO (i.e., whether the primary lesion resides at the level of the hypothalmus, ovaries or elsewhere) remains enigmatic.

Recently a new syndrome consisting of hyperandrogenism, insulin resistance and acanthosis nigricans (HAIR-AN) has been described.[6] In HAIR-AN patients the velvety, verrucous and hyperpigmented lesion of acanthosis nigricans accompanies the hirsute state. This characteristic lesion typically occurs under the arms or over the nape of the neck. In HAIR-AN patients, as well as in women with other insulin-resistant states and perhaps even in some individuals with PCO, hyperinsulinemia may be the cause of the hyperandrogenism. Several in vitro studies have demonstrated a stimulatory effect of insulin on ovarian steroidogenesis[7–9] and preliminary studies currently underway in several laboratories suggest that hyperinsulinemia can lead to hyperandrogenism in vitro as well.[10–13]

Table 1. Causes of Hirsutism in Women

Ovarian
- Polycystic ovary syndrome
- Hyperinsulinemia: syndrome of hyperandrogenism, insulin resistance, acanthosis nigricans (HAIR-AN); insulin-resistant states (e.g., Type B insulin resistance, lipoatrophic diabetes, leprechaunism, etc.); polycystic ovary syndrome (?)
- Androgen-producing ovarian tumors

Adrenal
- Cushing's syndrome (hypercortisolism)
- Virilizing forms of classical/nonclassical congenital adrenal hyperplasia: 21- or 11-hydroxylase deficiency; 3β-hydroxysteroid dehydrogenase deficiency
- Androgen-producing adrenal tumors

Drugs
- Androgens, corticosteroids, phenytoin, minoxidil, cyclosporine, diazoxide, penicillamine

Idiopathic
- Increased 5α-reductase activity (?)

A rare cause of excess ovarian androgen production is an ovarian tumor. Androgen-producing ovarian tumors typically present with menstrual dysfunction and serum total testosterone levels consistently in excess of 200 ng/dl.[14] The clinician needs to keep in mind that some women with PCO will present with random serum total testosterone levels >200 ng/dl; however, the testosterone level in these individuals usually fluctuates and is not consistently elevated.[14] Therefore, in the absence of symptoms or signs of virilization, several total testosterone levels consistently >200 ng/dl should be obtained before proceeding to an invasive evaluation based on this laboratory test alone. Conversely, if symptoms or signs of virilization are present in the absence of a highly elevated serum testosterone level, an aggressive workup should still be initiated. Ovarian androgen-producing tumors most often are sex cord-stromal tumors (granulosa-stromal cell and Sertoli-Leydig cell tumors), lipoid cell tumors or adrenal rest tumors.[15,16] These tumors can usually be palpated at adnexal examination[17] or demonstrated by pelvic ultrasonography.

Hirsutism may be caused by an adrenal abnormality, including hypercortisolism due to Cushing's syndrome (pituitary-dependent Cushing's disease, the ectopic adrenocorticotropin (ACTH) syndrome, or an adrenal adenoma). Usually, however, Cushing's syndrome presents with excessive growth of vellus hair.

Occasionally an androgen-producing adrenal carcinoma or adenoma may be the cause of hirsutism. Adrenal carcinomas are typically inefficient producers of androgens and thus are large at presentation and frequently palpable on abdominal examination.[18] They secrete primarily dehydroepiandrosterone (DHEA) and dehydroepiandrosterone-sulfate (DHEA-S), and serum DHEA-S levels are usually grossly elevated (>700 ug/dl). Androgen-producing adrenal adenomas are very rare,[19] but are much more efficient producers of an-

drogens and can be quite small upon presentation. They secrete primarily testosterone and can usually be detected by computed tomography (CT) or sonography of the abdomen.

The virilizing forms of classical congenital adrenal hyperplasia (CAH) (either 21-hydroxylase deficiency, 11-hydroxylase deficiency or 3β-hydroxysteroid dehydrogenase deficiency) almost always present at birth with ambiguous genitalia and occasionally, in the case of 21-hydroxylase deficiency, with salt-losing nephropathy.[20,21] Because the presentation of the classical CAH syndrome is seldom subtle, these entities will not be discussed any further in this review. Of greater import is the recent realization that nonclassical (also called attenuated, incomplete, acquired, late-onset or adult-onset) CAH can present in adult life as hirsutism.

The prevalence of one of these syndromes, nonclassical 21-hydroxylase deficiency, has been reported in limited series to be as low as 1%[22] of the hirsute population to as high as 25%.[23] Possibly the largest series to date was reported by Kuttenn and colleagues,[24] who extensively evaluated 400 consecutive hirsute women. Six percent (24/400) of these women were found to have nonclassical 21-hydroxylase deficiency. The severity of hirsutism in the women who had nonclassical CAH varied widely, from extremely mild to frank virilization. Interestingly, nonclassical 3β-hydroxysteroid dehydrogenase deficiency, which was once thought to be rare, may be even more prevalent than nonclassical 21-hydroxylase deficiency.[25,26] Nonclassical 11-hydroxylase deficiency, however, is still thought to be extremely rare.[27] Although further information regarding the prevalence of nonclassical CAH is needed, these studies suggest that these syndromes may be responsible for the hyperandrogenism of 5-15% of the hirsute population.

As demonstrated in Figure 1, the enzyme 21-hydroxylase attaches a hydroxy group to carbon 21 of 17-hydroxyprogesterone, thereby converting it to 11-deoxycortisol. A partial block of this enzyme, as is present in nonclassical 21-hydroxylase deficiency, leads to insufficient production of cortisol. This deficit in cortisol production results in decreased inhibition by cortisol of ACTH secretion from the pituitary. Therefore the ACTH level rises, which then stimulates the steroid biosynthetic pathways of the adrenal cortex. An equilibrium is finally attained where sufficient cortisol is produced but at the expense of adrenal hyperplasia and the accumulation of excessive amounts of androgen precursors proximal to the enzyme block, especially of 17-hydroxyprogesterone.

In similar fashion a partial block of the enzyme 3β-hydroxysteroid dehydrogenase, which converts Δ^5 steroids (such as 17-hydroxypregnenolone) to their Δ^4 counterparts (such as 17-hydroxyprogesterone), results in an excessive accumulation of precursor Δ^5 steroids.

In classical CAH, basal measurements of serum 17-hydroxyprogesterone or 17-hydroxypregnenolone would suffice to make a diagnosis of 21-hydroxylase or 3β-hydroxysteroid dehydrogenase deficiency respectively. In nonclassical CAH, however, these basal

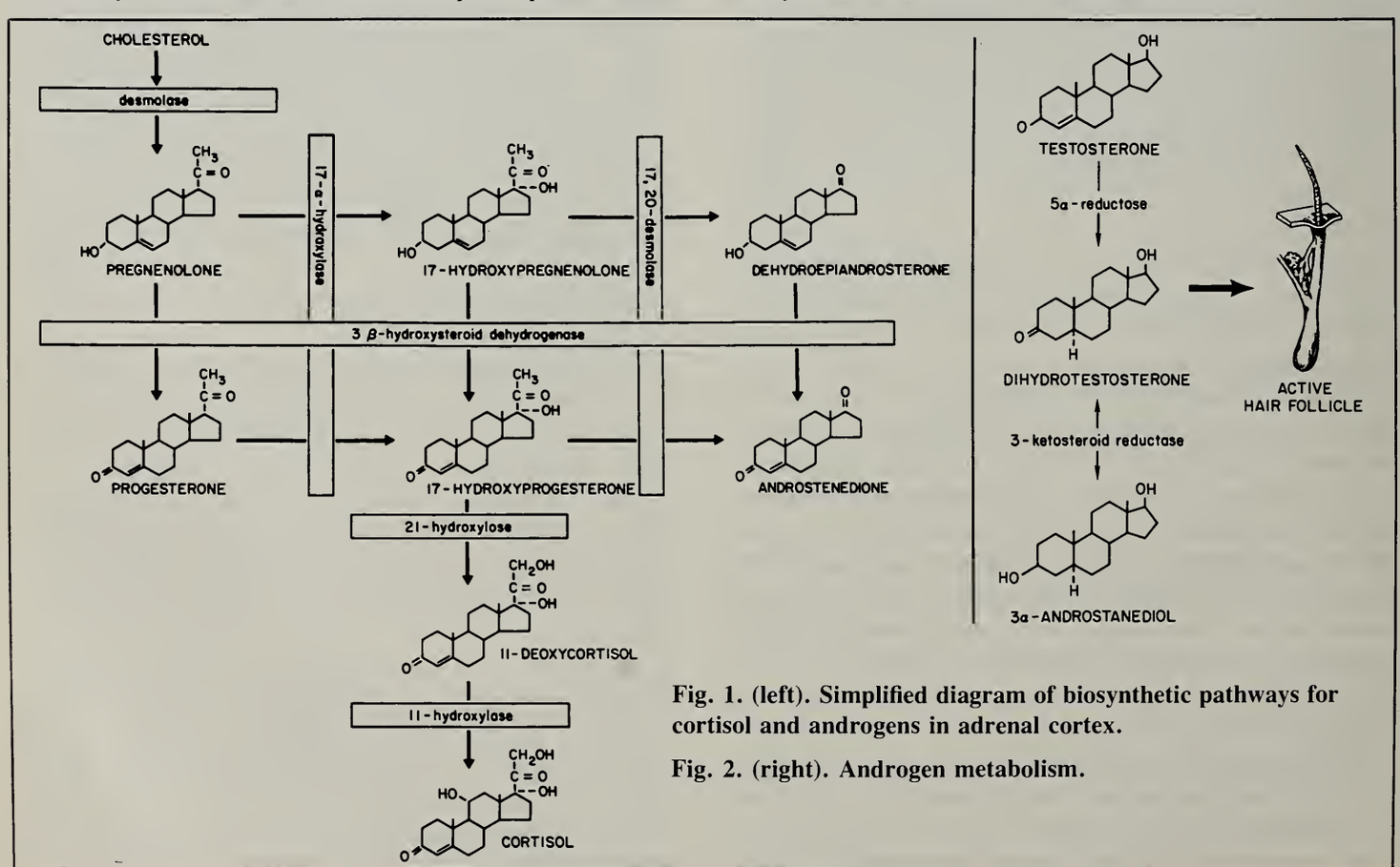

Fig. 1. (left). Simplified diagram of biosynthetic pathways for cortisol and androgens in adrenal cortex.

Fig. 2. (right). Androgen metabolism.

serum steroid values overlap substantially in normal and affected individuals.[26] Much more useful is the measurement of either serum 17-hydroxyprogesterone or 17-hydroxypregnenolone one hour following stimulation with 25 units of synthetic ACTH (Cortrosyn®). This is because the characteristic feature of a partial enzyme block is that the precursor:product ratio increases with stimulation. For example, in the woman with nonclassical 3β-hydroxysteroid dehydrogenase deficiency the ratio of 17-hydroxypregnenolone to 17-hydroxyprogesterone (i.e., Δ^5 steroid:Δ^4 steroid ratio) is about 2–3 in the basal state. Following stimulation with ACTH, however, this ratio is usually greater than 10.[26] For practical purposes, a diagnosis of nonclassical CAH should not be considered unless the post-ACTH stimulation value for either 17-hydroxyprogesterone or 17-hydroxypregnenolone exceeds 2000 ng/dl or 1500 ng/dl respectively.[26]

Drug use may be an infrequent cause of hirsutism.[28] Drugs which produce hirsutism include androgens, minoxidil, diazoxide, phenytoin, corticosteroids, penicillamine and cyclosporine. The pathophysiology of drug-induced hirsutism, other than that of androgens, is poorly understood. Most of the above drugs result in excessive growth of vellus rather than terminal hair.

Once all other causes of hirsutism have been excluded a diagnosis of idiopathic hirsutism is usually made. The term idiopathic hirsutism may soon become a misnomer, since evidence suggesting pathogenic mechanisms for the hirsutism of many women has been mounting. Testosterone does not act directly on the hair follicle to convert nonpigmented vellus hair to pigmented terminal hair but must first be converted by the intracellular enzyme 5α-reductase to dihydrotestosterone (DHT) to be active (Fig. 2). In this sense testosterone acts as a prohormone. and DHT is the active hormone which exerts an effect on the target organ. It has been postulated that the tissues of women with idiopathic hirsutism possess greater 5α-reductase activity than those of normal women, resulting in higher DHT levels. In vitro studies have demonstrated increased 5α-reductase activity in labial and pubic skin biopsies of women with idiopathic hirsutism.[29,32] However, it should be noted that in one limited study, increased 5α-reductase activity could not be demonstrated in the hair follicles of women with idiopathic hirsutism.[33]

Additional studies demonstrating increased 5α-reductase activity in women with idiopathic hirsutism have utilized measurements of the primary metabolite of DHT, i.e., 3α-androstanediol (Fig. 2), or, in its water soluble form, 3α-androstanediol glucuronide. In one interesting study Gompel and colleagues[34] collected 24-hour urinary measurements of 3α-androstanediol glucuronide and showed that women with idiopathic hirsutism had 1) higher basal excretion rates of 3α-androstanediol glucuronide than normal women and 2) marked enhancement of 3α-androstanediol glucuronide excretion when androstenedione was administered transdermally. Normal women demonstrated only a modest elevation under the same conditions. More recently, Kirschner and colleagues[35] utilized plasma 3α-androstanediol glucuronide measurements to follow the clinical response of 17 women with idiopathic hirsutism to various treatment modalities. Plasma 3α-androstanediol glucuronide fell dramatically as the hirsutism of these women ameliorated and in four of these women rose again as therapy was discontinued. These investigators found that plasma 3α-androstanediol glucuronide was a good biochemical marker of the clinical course of idiopathic hirsutism, whereas plasma total testosterone, free testosterone and androstenedione were not.

Therefore, evidence is accumulating to suggest that in some individuals idiopathic hirsutism is caused by increased 5α-reductase activity. An interesting and unanswered question is whether ethnic and racial differences in hair growth and distribution may also be attributed eventually to inherited differences in tissue 5α-reductase activity.

Laboratory Evaluation

If a woman presents with simple hirsutism the following tests are warranted: 1) serum total testosterone in order to exclude an ovarian or adrenal tumor (if the level is consistently >200 ng/dl an aggressive workup to exclude an ovarian malignancy or adrenal adenoma is indicated); 2) serum DHEA-S in order to exclude an adrenal adenoma or carcinoma (if the level is >700 μg/dl a CT scan of the abdomen should be obtained); 3) an overnight 1.0 mg dexamethasone suppression test in order to exclude Cushing's syndrome (when dexamethasone 1.0 mg is taken orally at 2300 h a serum cortisol level drawn at 0800 h the following morning should be <5.0 μg/dl); and 4) serum levels of 17-hydroxyprogesterone and 17-hydroxypregnenolone drawn one hour poststimulation with synthetic ACTH in order to exclude the nonclassical CAH syndromes. Although some clinicians would perform the overnight dexamethasone suppression test only if signs suggestive of Cushing's syndrome were present, we believe the presentation of this disorder to be sufficiently variable and subtle to warrant this noninvasive and relatively inexpensive test.

The clinician should be aware that even when the serum total testosterone level is normal the free testosterone level may be elevated. This is so because circulating testosterone is highly bound to sex hormone-binding globulin, which is decreased in hyperandrogenic states. Therefore, some clinicians might also like to obtain a free testosterone level in order to confirm hyperandrogenism and/or to utilize this measurement in following the efficacy of therapy. Commercial assays for plasma 3α-androstanediol glucuronide are now available and may prove more reliable for these purposes.

If menstrual dysfunction accompanies the hirsute state, it should be evaluated as well. Serum prolactin,

LH, and FSH levels should be drawn if oligomenorrhea is present. Although some authorities suggest that gonadotropin levels need not be obtained,[36] they may prove useful in supporting the diagnosis of PCO. If frank amenorrhea is present, a serum estradiol level is indicated as well. Hyperprolactinemia per se can result in a mild elevation of serum DHEA-S,[37] but is unlikely to do so in the absence of galactorrhea or menstrual irregularity.

If symptoms or signs of virilization are present, a CT scan of the adrenals and an ultrasound of the ovaries should be obtained. If these tests prove unrevealing, catherization of the adrenal and/or ovarian veins may be required to exclude a malignancy.

Treatment

When an androgen-secreting neoplasm has been discovered, operative removal is indicated.

When a patient has idiopathic hirsutism and the excess hair growth is localized to just one or two discrete areas, local measures frequently suffice. These include electrolysis, bleaching, shaving or the use of depilatories. If the hirsutism is more severe or diffuse, drug treatment is often utilized. For hirsutism accompanied by normal menses, spironolactone (50-200 mg/day) is frequently the drug of choice.[38] Spironolactone possesses multiple antiandrogenic properties, including inhibition of testosterone synthesis, 5α-reductase activity, and DHT binding to the androgen receptor.[36,39] The main side effect of spironolactone is metrorrhagia,[40] which occurs more often at higher doses and may necessitate discontinuation of the drug. Spironolactone may possess some teratogenic properties; therefore, the sexually active woman should be advised about adequate contraceptive measures. Another drug which has been used as an antiandrogen is cimetidine,[41] but it is less effective than spironolactone and not commonly used.

If hirsutism is accompanied by menstrual dysfunction, such as the unopposed estrogen state of PCO, oral contraceptives are helpful and serve a dual purpose. Not only may they lower serum androgen levels by suppressing gonadotropin release, but they also protect the endometrium from developing endometrial hyperplasia due to unopposed estrogenic stimulation. Oral contraceptives containing 35–50 μg of ethinyl estradiol and 0.5–1.0 mg norethindrone or 1.0 mg ethynodiol diacetate appear to be more efficacious in ameliorating hirsutism than the very low-dose birth control pills presently available on the market.[42] Other progestins, such as norgestrel, should be avoided since they possess some androgenic activity.[43]

Corticosteroids have been commonly used in the treatment of hirsutism and can be effective.[44] However, the reaponse rate is variable (25–50%) and the potential complications of therapy (including adrenal insufficiency during periods of stress) can be significant. Therefore, we do not recommend steroids for the routine treatment of hirsutism. If, however, alternative therapeutic modalities have failed or produced intolerable side effects, a trial of steroid therapy may prove useful. We recommend treatment with no more than 0.5 mg of dexamethasone given at bedtime.

Steroids are, on the other hand, specifically indicated in the treatment of hirsutism due to nonclassical CAH. Doses of 0.5–1.0 mg dexamethasone at bedtime are utilized to suppress the morning rise of ACTH levels. This therapy should result in a fall in circulating levels of adrenal androgens. The efficacy of steroid suppression therapy can be followed by serial measurements of 24-hour urinary 17-ketosteroids, and the dose of dexamethasone can be adjusted on this basis. It may be advisable for women taking corticosteroids for adrenal suppression to wear a bracelet or necklace which would alert health care providers to this fact.

Recently gondotropin-releasing hormone (GNRH) agonists have been used to treat women with idiopathic hirsutism or PCO.[45] This treatment resulted in reduced serum levels of gonadotropins, ovarian androgens and estrogens, and in amelioration of the hirsutism. Side effects included menopausal symptoms, anovulation and amenorrhea. The use of GNRH agonist therapy may require the addition of physiological doses of estrogens, with periodic progestin withdrawal, to prevent the development of osteoporosis. In the future GNRH agonist therapy may become standard treatment of hyperandrogenism of ovarian origin.

Finally, one should remember that the patient with hirsutism needs to be reassured. The hirsute woman frequently worries that her disorder is a serious one or that she is "different" from her peers. The clinician should emphasize to the patient that hirsutism is a common disorder and that treatment modalities exist which will benefit the patient.

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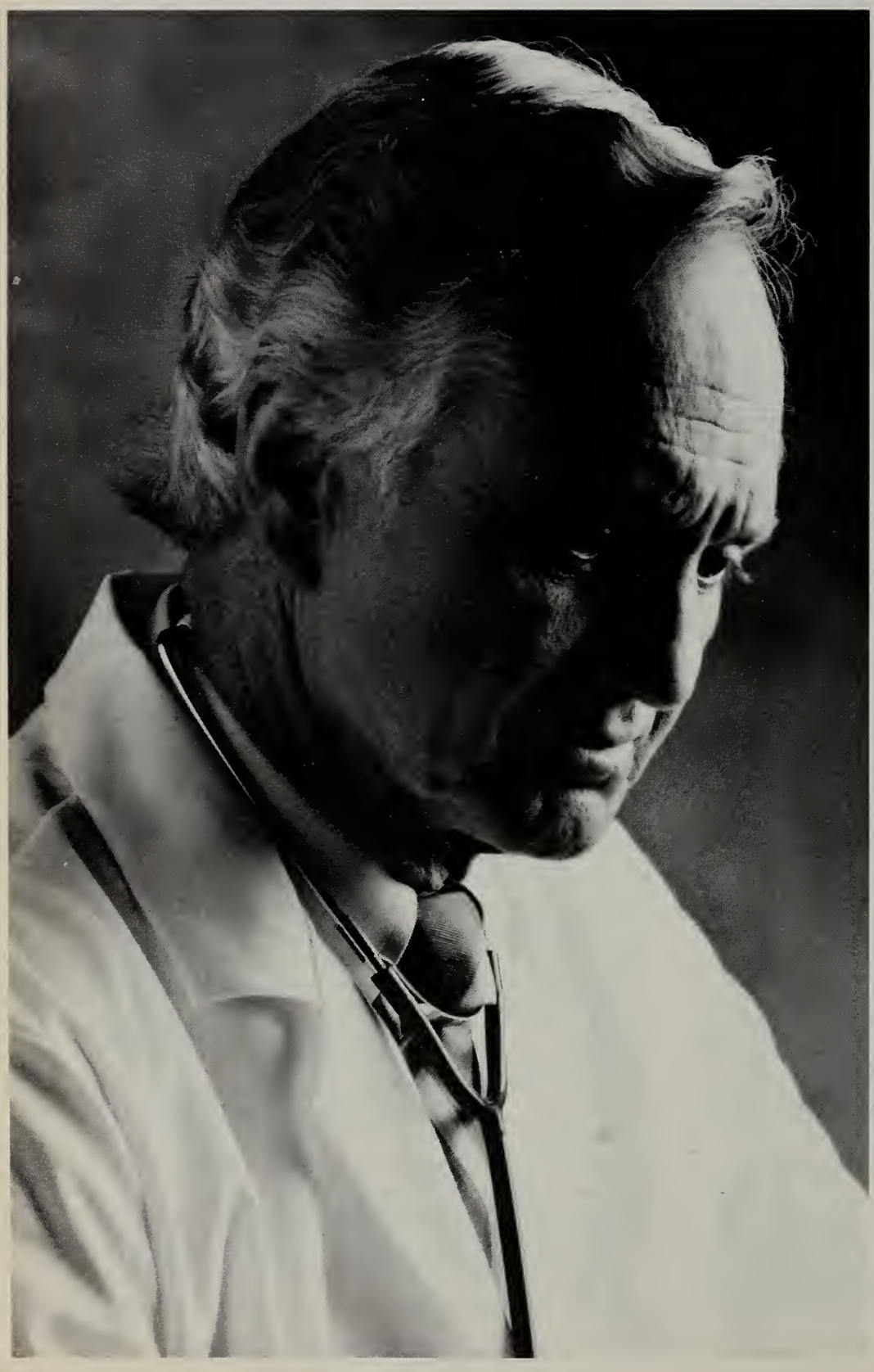

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Current Status of Cochlear Implants in Adults, Children

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In 1957 an electrode was implanted on the auditory nerve of a deaf teenage boy in France.[1] After surgery this patient was able to hear sound. In the three decades following this landmark achievement, an intense effort by many disciplines—otolaryngology, audiology, neuroscience, speech pathology, biomedical engineering, and others—has proven that 1) the peripheral auditory system can be safely stimulated electrically and 2) that this stimulation can result in the perception of sound. The device accomplishing this has been termed a cochlear implant (CI), and it represents medicine's first successful attempt at replacing a major sense with an electronic instrument. Although the CI only begins to approximate the complexity of the human ear, which has over one million moving parts, it can consistently restore the perception of sound to properly selected individuals with profound sensorineural hearing loss (SNHL) and, as detailed in this report, in some cases provide a sufficient sound quality to permit the understanding of speech.

The physiologic principle upon which the CI is based concerns the differential loss of sensory and neural elements in the deaf patient. Almost all disease processes and traumas affecting the inner ear preferentially destroy the cochlear hair cells. The afferent auditory nerve fibers may undergo secondary degeneration, but in most cases at least some of the approximately 30,000 nerve fibers remain viable. These nerve fibers can be electrically stimulated and are capable of carrying complex information to the central auditory structures. Impulses resulting from electrical stimulation arrive at the auditory cortex looking like acoustically generated signals, and are thus interpreted as sound.

Almost 3,000 CIs have been implanted in adults and children on a worldwide basis. A number of designs have been used, and they can be catagorized on the following bases: channels (single versus multiple), electrode insertion (outside versus inside the cochlea), and sound processing strategy (certain speech features extracted versus presentation of complete speech signal).

All CIs consist of three components which are worn externally and two which are implanted surgically (Fig. 1). The external parts are a microphone which picks up the sound, a signal processor which modifies or extracts information from the speech signal and codes it, and a transmitter which relays the processed signal across the skin (usually by electromagnetic induction) to an implanted receiver. The two internal components are the receiver and an attached electrode array. The receiver decodes the signal from the transmitter and sends that information to the appropriate electrode(s). The electrode array is usually implanted within the scala tympani of the cochlea.

Six different implant designs are being actively investigated in this country. Two of these devices, the House-3M single channel implant and the Nucleus multichannel implant, have received FDA approval for use in adults (1984 and 1986 respectively). Both of these devices are undergoing FDA trials in children, but neither has been approved for patients under 18 years of age. Although the House device has been the most widely used of any implant system, the majority of adults are now receiving the Nucleus cochlear implant because of its multielectrode design and more sophisticated speech processing strategy. A recent NIH Consensus Development Conference concluded

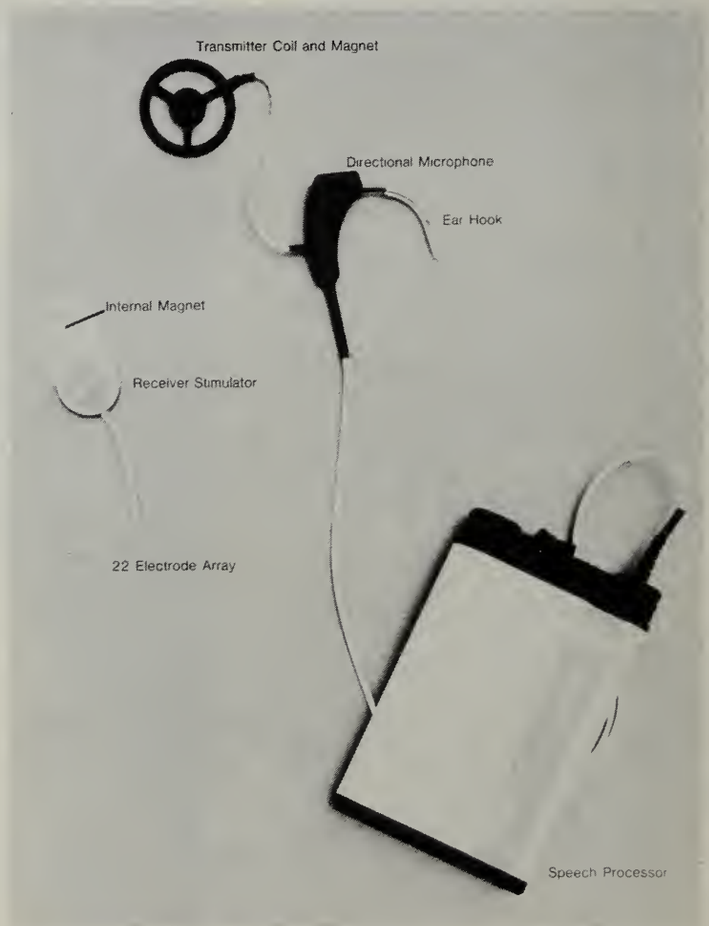

Fig. 1. Component parts of the Nucleus 22 channel cochlear implant.

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that "multichannel intracochlear stimulation produces superior speech-recognition performance compared with single-channel stimulation."[2]

Considerations for Candidacy

The optimal candidate for a cochlear implant is an adult patient who recently (months to several years) suffered a profound bilateral SNHL. Such a patient will have normal speech development and an excellent memory for sound. A strong desire to regain some hearing ability and a supportive family are also important. The etiology of the deafness does not bear any clear relationship to subsequent implant performance.

Adult patients with congenital deafness or loss of hearing during the first few years of life (prelinguistic deafness) experience only modest benefit with the CI. Development of the auditory pathways and maintenance of their integrity are perhaps both negatively affected by the early onset of deafness and its long duration. Also, the patient will have made a psychological adjustment to the deafness and attempts to alter this situation with a CI may be counter productive.

As with adults, children with postlinguistic deafness demonstrate better initial gains with the implant than those with congenital or prelinguistic deafness. The relatively short duration of deafness in the latter children and the greater plasticity of the young child's neurological system, however, have encouraged investigators to suggest that even these children with early onset deafness will gain substantial benefit from a CI. A prognostic factor unique to children is their educational setting, with those being educated in an oral-aural program seeming to perform better than those in a strictly manual program.[3]

Patient Evaluation

The implant evaluation involves a general history and physical examination, a detailed audiological assessment, a CT scan of the temporal bones, and a psychosocial evaluation. Of initial concern is the status of the patient's general health, which must permit a general anesthesia and 4-5 hour surgical procedure, and the absence of ear disease, such as acute or chronic otitis media, tympanic membrane perforation, or cholesteatoma. The CT scan is obtained to document normal development of the inner ear and patency of the cochlea. This latter determination is particularly important in patients deafened by meningitis or other inflammatory conditions. In such cases bone deposition can occur within the fluid spaces of the cochlea (labyrinthitis ossificans) and, if extensive, preclude insertion of an intracochlear electrode. The psychosocial assessment is useful in evaluating the patient's intelligence level and, equally important, how deafness has impacted on his/her life. Also, information regarding the patient's and family's desire for the implant, postimplant expectations, and probable commitment to the rehabilitation program is obtained.

A critical assessment in determining CI candidacy is the audiological evaluation. This evaluation is designed to explore: 1) the actual degree of residual hearing function; 2) the extent to which a conventional sensory device, such as a hearing aid, may be successfully utilized to maximize the patient's auditory abilities; and 3) the viability and nature of auditory sensation in response to electrical stimulation of the cochlea.

According to current selection criteria, a patient must have a profound SNHL bilaterally in order to be considered a candidate. As such, the initial phase of evaluation consists of a basic audiogram to determine the extent of residual hearing. In some cases auditory brainstem response audiometry is also included in the test protocol to confirm the audiometric results. Once the presence of a profound SNHL has been established, the next step is to determine whether the patient can receive benefit from a more conventional sensory aid (hearing aid, auditory trainer, vibrotactile device). This is accomplished by presenting a wide variety of speech-type test material to patients fitted with maximal amplification devices. Comparison is then made in their ability to perform these same tasks without a sensory aid. If no change in performance is noted, the patient is considered a possible CI candidate and further testing is pursued. Extended trial use of a conventional sensory device over a period of several weeks or more is often recommended when it is suspected that a patient's failure to use the aid successfully is due to improper fitting or lack of sufficient experience with amplification. Such a trial period combined with a rehabilitation program is particularly important in children, and can last six months or longer.

As previously stated, the basic concept underlying use of a CI is that the deaf patient still has excitable auditory nerve fibers capable of carrying information centrally. Currently the best approach for addressing this question is to observe the patient's response to small electrical signals delivered to the ear via a needle electrode placed through the tympanic membrane to the promontory wall of the middle ear. This testing, referred to as promontory stimulation, is designed to simulate, as nearly as possible, several conditions similar to that which would occur in an actual implant. The following responses are obtained during promontory stimulation testing: threshold, uncomfortable level, pitch/frequency discrimination, temporal resolution, adaptation or fatigue, and subjective perceptions of quality. By analyzing the nature of these responses, the probable success a patient might experience from a CI can be determined. For example, failure to obtain a response with promontory stimulation would tend to exclude the patient from consideration for a CI.[4]

Surgical Procedure and Risks

The operative approach requires a wide postauricu-

lar incision, a mastoidectomy, and fenestration of the cochlea. The implant recipient is usually hospitalized for two days. The main surgical risks are infection, which could result in rejection of the device, and facial nerve injury; both of these potential complications are on the order of 1%. The risks of chronic electrical stimulation of the inner ear and central nervous system are unknown, but no significant untoward effects have been reported in over 15 years of experience with the CI in several thousand patients.

The surgery for implanting a CI in children over 2 years of age is similar to that for adults. The cochlea is fully developed anatomically at birth, thus no change in electrode size is needed. There is rapid mastoid growth to age 4 years and then slower growth of the temporal bone until about age 10. In anticipation of this head growth, sufficient allowance must be made for electrode lead redundancy. The surgical risks are the same in children as adults. Because the implant crosses the middle ear and is a foreign body, there is the potential problem of increased difficulty in eradicating middle ear infections, which are common in this age group. A second concern is the possibility of a middle ear infection spreading along the implant's path into the inner ear and then to the cerebral spinal fluid. Although theoretical concerns, these potential complications have not occurred in the several hundred children who have thus far received a CI.

Rehabilitation

Approximately one month after surgery, when satisfactory healing has occurred, the patient receives the external parts of the CI and learns how to manipulate them. The major consideration at this time is programming the speech processor. Using a computer interface with the speech processor, each of the 22 electrodes (Nucleus type CI) are electrically stimulated. The patient provides feedback as to the presence or absence of sound and its quality, both in terms of loudness and pitch. Patients commonly undergo several reprogrammings of the speech processor as they become reaquainted with sound over time.

For an adult, the initial rehabilitation session requires 3-5 days of training. Several additional visits of 1-2 days are necessary during the next several months, and then followup visits are scheduled every six months. Because of the added complexities of programming the speech processor in a child who is unable to give sophisticated feedback, the time for rehabilitation is significantly longer.

Results

Seventeen patients received cochlear implants at the University of Virginia Health Sciences Center from 1984 to 1989. The patients range in age from 4 to 67 years. The first three patients received a House single channel implant; all subsequent patients were implanted with the Nucleus multichannel device. Of these 17 patients, one is deceased and one had the device explanted because of failure to respond to electrical stimulation; two patients are in the initial phases of the rehabilitation program; the remaining 13 patients are users. The current implant users were sent a questionnaire inquiring about their perceived benefits of the CI; all completed and returned the form.

Analyzing the data from this questionnaire confirmed our impression that two of our patients (both adolescents) use CI sparingly during the day and receive only minimal benefit from it. Conversely, one of the patients receives exceptional benefit from the device and functions more like an individual with only a partial hearing loss. All the other patients cluster in the mid-range between these extremes. The three patients with single channel implants did not perform quite as well in those tasks requiring speech understanding; nevertheless, the addition of their scores did not change the medians and they are included in the results. The data can be summarized as follows:

1. *Quality of Sounds*: Median score 4.0; 5-point scale. Patients were able to discern environmental sounds (including the differentiation of voices) between 50% and 100% of the time.
2. *Lip Reading*: Median score 3.5; 4-point scale. Patients reported moderate to exceptional improvement in lip-reading ability.
3. *Speech Production*: Median score 3.0; 4-point scale. Patients reported mild to moderate improvement in the quality of their voices.
4. *Speech Understanding*: Median score 2.5; 5-point scale. Patients reported that with a familiar speaker (e.g., family member) many words could be understood without lip reading. Very few words, however, were understandable with an unfamiliar speaker.
5. *Telephone Use*: Median score 2.5; 5-point scale. Patients consistently reported that they could engage in a simple yes/no telephone conversation with any speaker and in a somewhat more complex conversation with a family member.
6. *Personal Security and Safety*: Median score 3.5; 4-point scale. Patients felt a marked improvement in personal safety and feeling of security.
7. *Stress*: Median score 4.0; 4-point scale. Patients noted moderate to profound reduction in daily stress.
8. *Quality of Life*: Median score 3.5; 4-point scale. Patients reported moderate to profound improvement in overall quality of life.

Ten of the 13 patients stated they would recommend the CI to a deaf friend. The two patients noted above who seem to derive minimal benefit from the CI would not recommend the device, and one patient stated he would take a neutral stance. The implant was used at least 16 hours a day by five of the 13 patients; the mean usage was 13 hours (range 3-18 hours per day).

Conclusions

The cochlear implant (especially the multichannel

design) has made a profound impact on the rehabilitation of deafness. The full realization of this impact is predicated on proper patient selection and a dedicated CI team. Although the CI does not restore hearing per se, it does enable the deaf patient to once again enjoy auditory contact with the environment. Communication is easier, both in terms of lip reading ability and, for a few patients, the understanding of speech without visual cues. Patients perceive the implant as enhancing independence, self-esteem, and ability to fulfill personal ambitions.

All these benefits can be expected in the majority of properly selected, postlingually deafened adult patients. The collective data from children in this country who have received a CI are preliminary, but most investigators feel that this patient group will be able to utilize the device to an equal or perhaps greater extent.

Acknowledgement

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Point of View: Wellness

Look in any journal, newspaper, magazine and bookstore and you see wellness! Look at advertising by various health insurers, hospitals and quasi-governmental agencies and you see wellness! Look at the reams of information developed by medical benefits designers and you see wellness!

Wellness seems to be on the minds of growing numbers of our population. Witness the growing number of fitness centers, weight reduction parlors, joggers everywhere. Is this a fad? A passing fancy? Is the traditional medical practitioner being replaced now by the "wellness advisor"? Is the annual physical examination being replaced by "lifestyle modification"?

What is the role of the physician in all this? Can the traditional practitioner trained in diagnosis and treatment of disease switch roles and on occasion become an advocate of "complete physical, mental and social well-being"?

Physicians know that heart disease is the nation's No. 1 killer, but according to a study by the British Medical Research Council, doctors can really help a patient only about 12% of the time. Lifestyle changes, however, can prevent illness 54% of the time.

Along these same lines, the report mentions the following:

- "Where stroke is concerned, physicians can help about 7% of the time in averting the onset, while 50% of the time stroke is the direct result of lifestyle choices people have made.
- "Where cancer is concerned, individual lifestyle choices are a major factor 37% of the time.
- "Today, nearly 60% of all US males are overweight.
- "Lung disease begins within a few days of a new smoker's first cigarette. The good news: early in the smoking habit, quitting leads to almost complete reversal."

A study by the Massachusetts Mutual Life Insurance Company states that hypertension in active employees is the cause of ten times more hospitalization than in controlled hypertensives. With screening and control, absenteeism usually drops to normal, and long-range health costs drop sharply.

With medical training as a background, physicians are eminently qualified to become specialists in wellness, and as public interest grows, so should we, as a profession, take a leadership role in this vital and worthwhile movement.

For starters, we should seek time and space in the media; we should seek to address public interest groups; and we should look for opportunities to start screening programs in the workplace and other appropriate public places.

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ABSTRACTS

These are abstracts of papers presented on April 21-22 at the annual meeting of the Virginia Society of Otolaryngology in Irvington. Dr. White McK. Wallenborn presided.

Disorders of Hemostasis and Their Clinical Significance in Otolaryngology. Christopher D. Rucker, MD, and Gary L. Schechter, MD, Norfolk.

It has long been known that preoperative evaluation of a patient's blood coagulation system is necessary under certain clinical circumstances. The classical coagulopathies still threaten the safety of patients undergoing surgical procedures. In addition to these problems, there are threats from drug-induced bleeding disorders.

This presentation outlines current concepts of biochemical reactions in the coagulation system and points to the dysfunctions caused by familial and acquired disorders. Preventive measures are discussed.

Pseudotumor Clavicula: A Rare and Perplexing Sequelae of Radical Neck Dissection. Danny A. Neal, MD, Paul A. Levine, MD, and Thomas L. Pope, MD, Richmond.

Complications associated with radical neck dissection have been well documented since Crile's initial description of the procedure in 1906. In 1985 Fini-Storchi defined the radiographic appearance and physical findings of an uncommon medial clavicular swelling rarely reported in patients who had prior neck dissections, an entity he labeled "pseudotumor claviculi".

We report two cases of this unusual complication following head and neck radiation and radical neck dissection, and describe the clinical and radiological findings along with the pathologic diagnosis. Use of fine needle aspiration cytology, rather than excisional biopsy, will be discussed in conjunction with a review of metastatic disease to the clavicle and of how to differentiate this entity from metastatic bone disease.

Venous Hum Tinnitus: More Than Meets the Ear. George T. Hashisaki, MD, Paul R. Lambert, MD, Robert Ferguson, MD, and Paul A. Levine, MD, Charlottesville.

Most commonly, the diagnosis of tinnitus connotes incurability. Therefore, making an accurate diagnosis of pulsatile tinnitus secondary to a venous hum is significant, as surgical intervention can be curative. While the diagnosis can be made in most cases by a complete physical examination, cerebral angiography is essential to confirm the absence of other vascular lesions and to define the cerebral venous outflow before considering internal jugular vein ligation.

A representative case of venous hum tinnitus is presented in which ligation of the internal jugular vein would probably have impaired cerebral venous drainage and precipitated more serious long-term problems. We review the evaluation of the patient with pulsatile tinnitus, the most common etiologies, and discuss the role of internal jugular vein ligation for pulsatile tinnitus secondary to a venous hum.

Monitoring Facial Hyperkinesis During Microvascular Decompression For Hemifacial Spasm. Richard L. Prass, MD, Norfolk.

Hemifacial spasm may be the only "vascular loop" syndrome with a physiological correlate. A late electromyographic response may be recorded in the mentalis muscle with electrical stimulation of the zygomatic branch of the facial nerve, presumably due to ephaptic transmission among facila nerve fibers. Others have suggested that intraoperative disappearance of this response temporally correlates with microvascular decompression of the facial nerve.

In the present study, the zygomatic branch of the facial nerve was repetitively stimulated during a microvascular decompression procedure for hemifacial spasm. Electromyographic activity of the orbicularis oculi and mentalis muscles was recorded on the audio channels of operative videotapes for later review. During the course of surgery, the mentalis muscle response disappeared transiently with cerebellar retraction and permanently following use of electrocautery, away from the facial nerve and significantly prior to microvascular decompression. However, disappearance of irritable behavior in the orbicularis oculi response appeared to temporally correlate with microvascular decompression. The present observations may support either "minimal trauma" or microvascular decompression as the mechanism of surgical therapy. Further study may lead to better understanding of hemifacial spasm and other less well-documented vascular loop syndromes.

Infatile Myofibromatosis of the Temporal Bone: A Case Report and Review of the Literature. Lewis Hutchinson, MD, John Ward, MD, and Aristides Sismanis, MD, Richmond.

Infatile myofibromatosis is a rare inflammatory-proliferative disorder of fibroblastic origin, with local aggressive features. Head and neck manifestations of this disorder can mimic malignancy and otolaryngologists should be aware of this entity. We present a case

of a 9-month-old male with a six-week history of temporal region swelling. Our initial impression based on clinical and radiologic findings was that of a malignant process; however, biopsy revealed myofibromatosis. This case was treated with wide local resection.

Branchial Cleft Cysts: An Unusual Presentation. M. G. Mellis, MD, M. A. Frable, MD, D. L. Mobley, MD, Richmond.

Patients with branchial cleft cysts present infrequently to the practicing otolaryngologist. When the mode of presentation is an acutely inflammed mass, establishing the correct diagnosis and instituting appropriate treatment can be difficult. The authors present eight patients who presented at the Medical College of Virginia Hospitals with the acute onset of painful red neck mass between January 1968 and December 1988. Three patients underwent incision and drainage prior to establishing the correct diagnosis. Six patients underwent fine needle aspiration biopsy prior to establishing to surgical excision. This series stresses the importance of awareness of unusual manifestations of branchial cleft cyst.

Vascular Injury Following Foreign Body Perforation of the Esophagus: Review of the Literature and Report of a Case. Richard L. Scher, MD, Charles J. Tegtmeyer, MD, and W. Copley McLean, MD, Charlottesville.

Esophageal perforation resulting from foreign body ingestion is a rare occurrence. Most of the complications associated with this event, such as retroesophageal abscess, mediastinitis, pericarditis, pneumothorax and pneumomediastinum are widely recognized. However, little attention has been directed to the possibility of vascular injury caused by the perforating object. Isolated case reports have described significant morbidity and mortality subsequent to major vascular trauma resulting from an esophageal foreign body, usually emphasizing the presence of a "signal" hemorrhage from the gastrointestinal tract as a key to diagnosis.

In this report we describe a case of esophageal perforation caused by a fish bone, which resulted in significant aerodigestive hemorrhage presenting with the unusual symptom of hemoptysis, in which no identifiable, isolated vascular injury could be determined. The literature on vascular trauma following foreign body perforation of the esophagus is reviewed, and suggestions for the diagnosis and treatment of these dreaded complications are made.

Objective Tinnitus: Recent Advances in Diagnosis and Management. Aristides Sismanis, MD, George H. Williams, MD, and Susan M. Fowler, Richmond.

Objective tinnitus can be an ominous sign of serious intratemporal or intracranial pathology and therefore deserves thorough evaluation. The purpose of this presentation is to report our experience obtained over the past seven years in evaluating a large number of patients with objective tinnitus. The most common underlying diagnosis was found to be benign intracranial hypertension. We also present a new electronic device for the detection and recording of objective tinnitus as well as a protocol for evaluating these patients. A review of the literature and the results of our management are also presented.

Otologic Abnormalities Associated with Congenital Disorders of the Head and Neck. Scott R. Morin, MD, Howard N. Gutnick, PhD, and Richard L. Prass, MD, Norfolk.

The development of congenital disorders of the head and neck results from disruption of the sequential events necessary for closure of the primary stomadeum, branchial arches, and the uniform development of the upper respiratory and gastrointestinal systems. The same forces that disrupt the proper development of the craniofacial, respiratory, and alimentary structures also play a major role in the development of the ear. Many of the common congenital syndromes are associated with otologic abnormalities.

This presentation outlines the development of the ear and highlights the relationships of abnormality known to occur in the otologic structures in association with other anomalies of the head and neck.

Waveform Morphology and Amplitude Variability in Facial-Nerve Electroneurography. Michael J. Kelleher, MD, Richard L. Prass, MD, and Howard N. Gutnick, PhD, Norfolk.

At present, facial-nerve electroneurography (ENOG) is usually performed using bipolar stimulation over the facial-nerve trunk and bipolar recording in the nasolabial crease. This study assesses the effect of using monopolar vs bipolar recording electrodes in the nasolabial crease and the alae on ENOG waveform morphology and on the variability of ENOG waveform amplitude.

Five normal subjects had three trials of facial-nerve ENOG on three separate test days. Resultant peak-to-peak amplitudes of combined motor action potentials were measured and recorded using a clinical evoked-potential instrument. We found that the most consistent waveform shape was obtained by using the nasal alae as the recording point rather than the nasolabial crease. Amplitude variability of monopolar vs bipolar recording will be discussed.

VIRGINIA MEDICAL

EDITORIAL

The Work Ethic

EVERY physician thinks that he or she is a conscientious and diligent worker. However, this may be a matter of interpretation, and the duties requiring a full day for one may be considerably less demanding for another. Then there is the matter of effectiveness. One person may spend a long, hard day in a poorly organized approach with less than optimal results, while another achieves better results with less effort.

It is a privilege to recognize one who combines all the good qualities and attributes of a great physician: high moral and ethical values, diligence, intelligence, good judgment, compassion, and love of fellow man. One such person is retiring after 27 years as a member of the pediatric faculty of the Medical College of Virginia. She is Dr. Ruth Campbell and she will be sorely missed.

E.L.K., JR.

On Being Politic

HE was one of those men whom everyone instantly likes, one of the most politic, agreeable, and delightful of men that I have ever known. Most definitely he had a winning way with people. And I learned a lot from him as we served together on the board.

However, he had one habit which severely irritated me. Often he and I would privately discuss an issue which was about to come before the board for a vote. He would agree with me and say that our views were similar. But when it came time for the full board to vote, again I would be on the short end of an 8-1 count.

Finally I could no longer tolerate the situation, and I said to him, "Why is it that you agree with me but vote against me? It just doesn't seem right."

A look of embarrassment and contrition came across his face. He looked me straight in the eye, and said, "No, it doesn't seem right. I respect you and like you. I really hadn't thought about it. I didn't mean to upset you. It won't happen any more, I promise you."

And I knew that he would mend his ways. And he did. Now he disagrees with me. And continues to vote against me.

H. S. CAMPELL, MD

VMAPP

PHYSICIANS have historically provided medical care for those who cannot pay. Partial solution of this problem in older persons is now provided by Medicare. However, there are still those who cannot afford the difference between the Medicare assigned rate and the physicians' usual and customary charge; therefore, the medical profession must again assume at least partial responsibility for health care in this group. That is where the Voluntary Medicare Assignment Program for Physicians (VMAPP) comes in.

This program, championed by Dr. John A. Owen, Jr., and the Committee on Aging and endorsed by The Medical Society of Virginia now is on a roll. Already eleven of the 43 active component societies in Virginia have established a VMAPP program. Dr. Owen's own component society, the Albemarle County Medical Society, was the first to establish such a program. The others are: Alexandria Medical Society, Buchanan-Dickenson Counties Medical Society, Floyd County Medical Society, Fredericksburg Area Medical Society, Hampton Medical Society, Lynchburg Academy of Medicine, Newport News Medical Society, Norfolk

Academy of Medicine, Richmond Academy of Medicine, and Virginia Beach Medical Society.

In endorsing the VMAPP route for component medical societies, the Medical Society of Virginia's House of Delegates set January 1, 1990, as the deadline for implementation of the programs. It is hoped that many more societies will join the eleven listed above.

E.L.K., Jr.

Inner Space

It was a very hot and humid Saturday afternoon, and I was hot and tired. It always wears me out when I finally catch up with my mail and my charts. My wife and daughters were shopping, and a thunderstorm was on the horizon, cancelling my plans for a swim.

I decided to have an imported Hayem Shemon beer at Queenie's Tavern and relax for thirty minutes before supper. As I walked in the door, I passed Queenie, who was walking her dog, Roscoe P. Coaltrain. Roscoe is a magnificent black French poodle who reminds me of my own French poodle friend, Sidney.

Sidney, who died at 13 years old, loved to go to our mountain farm and ride in my 1969 Ford pickup truck. The air vent opened beneath the dash at the height of his nose. As soon as we were on the open road, he would "plug in" by inserting his nose into the air vent for the duration of the trip. Obviously he was "seeing" the countryside with his sense of smell and enjoying it immensely. Because dogs' vision is much worse than ours and because dogs' brains are much more devoted to smelling than seeing, his view of the country was nasal rather than ocular. I often wished that I could experience his range of smells, could know how exciting were the smells of the world.

Brooding about my faithful dog, I ordered my second Hayem Shemon and a big bowl of peanuts. Now that Sidney was dead, I loved my wife and children and mother first, and peanuts second. Talk about addictions and weaknesses. Peanuts are mine. Fortunately they are legal.

Hearing the crunching of the peanuts reminded me that dogs hear much better than we do, and birds of prey see much better than we do. Being almost tone deaf and absolutely unable to carry a tune, I wondered how music sounds through the ears of a musician. Having no artistic skills and a poor visual memory, I wondered how colors and pictures look through the eyes of an artist.

Ours is the age of rocket ships and trips to the moon. We talk about going further into outer space, but going into the inner space of another person would be just as interesting and enlightening.

H. S. Campell, MD

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FROM THE ROSTRUM

"The best there is anywhere, and the credit is ours!"

THE past few years have brought great changes, serious changes, which radically alter the environment in which we do things and even threaten to undermine the sacred and autonomous art of practicing medicine as we know it.

Recently I overheard a colleague whom we all respect turn to a friend and say, "The things happening in medicine today are nothing short of a revolution." It seems as though we are put upon at every turn ("besieged" is probably not too strong a word) and our very livelihood is at stake. Some have despaired and are looking for ways to get out early. Some have become defensive and are playing a holding game. Others are angry and are lashing back negatively at the system. All of us are affected by this new age, and we face a common concern and anxiety.

Yet, paradoxically, this year of 1989 is the best, most exciting, most opportune time in history to practice medicine. Surprised? It's true, and for many reasons. We know more and can do more than ever before. Our knowledge and the technology to implement it is at an all-time high, and the potential for success in handling patient problems has never been better. Ours is the best system in the world!

Think back just a few years.

For me it was 1960, Charity Hospital, New Orleans, Louisiana—"Mother Charity," "The Big Free," as it was variously called—19 floors of segregated, open wards—no air conditioning—rubber IV tubing—mix your own IVs—stainless steel needles—patients on IVs with chills and fever attributed to "pyrinogens" in the tubes.

In Surgery it was thread-your-own needles, no monitors to speak of, open windows, and the heavy smell of open drop ether and antiseptic. I remember the then chief of surgery, Dr. Oscar Creech, frequently dispatching a nurse to swat flies. Cardiac surgery had not really started, vascular surgery was in its infancy, we didn't have angiocaths, Fogarty catheters, butterfly needles, paper tape, etc.

In Psychiatry there was an acute lockup, a jail-like area surrounded by bona fide iron bars with a steel-caged nursing station in the center. Burly, bouncer-type orderlies circulated through a hyperactive, screaming, crowd of psychotic patients. There were no phenothiazines. Straight jackets and leather restraints were everywhere. I remember a sign that said, "No rectal exams on paranoid schizophrenics." It was a zoo—and despite everyone's good intentions, a place where hope and dignity were lost.

I remember also at that time in New Orleans a chronic care facility on Henry Clay Avenue. The place had a large, arched, wrought iron entranceway with the inscription: "Home for the Incurables".

For me also it was July 1970 at Roanoke Memorial Hospital. I remember walking through the front door of the old hospital with an operative list in hand provided by my senior partner, Dr. Peter Wallenborn, and having to ask Information where the OR was. The lady at the desk said, "It's on the fifth floor but you can't go up there." And I said, "But I've got this surgery list to do."

There were about six drab operating rooms. Joe Anderson and Bob Gleason were the only full-time anesthesiologists. There were two crowded ICUs. On Pediatrics there was a large sleeping porch with ten or twelve cribs lined up beside each other. Hall beds were commonplace. There was no pediatric or neonatal ICU, no trauma service, no CT scanner or MRI, no fiberoptics, no cath lab or cardiac surgery, and just so many other things were absent that we regard as commonplace essentials today.

Today we enjoy enormous luxury and convenience, and it occurs to me that much, if not most, of this has come about as a result of our intelligence, concern, inventiveness and long hours of hard work. We, or our

Excerpted from Dr. Grayson's inaugural address as president of the Roanoke Academy of Medicine on January 9, 1989. Address correspondence to him at 201 McClanahan Street SW, Roanoke VA 24014-0306.

colleagues whom we know by name and have slogged around many a hospital with, have done it, and we can be proud of it. We have produced through our own investigations and experiences a better way, time and time again—until today we have the best there is anywhere, the world model! And the credit for it is ours!

So what is all the fuss about? Why so much tension and despair? Why do we overhear our peers advising young people, even their own children, to stay out of medicine? Why is it that applications to medical schools have dropped from 2.7 per position ten years ago to 1.8 today? What are the problems?

The first is Money. There just isn't enough of it. Last year $500.3 billion was spent on health care, 11.1% of the gross national product. Society seems to be schizophrenic about this. On the one hand, everyone wants the freedom to choose the ultimate in luxury medical care, nothing but the best. On the other hand, few are willing to support and pay for a system which provides that kind of care. It *is* costly, but the reasons for this are not all bad. For instance, our population is aging and senior citizens require more frequent and longer periods of care. Also, it takes money and increased manpower to provide today's remarkable technology—magnetic imaging centers, mobile CT scanners, laser centers, state or the art operating rooms and ICU equipment, helicopter shuttles, and so on.

But who wants anything less? I have just flown my son 9,000 miles to have an MRI and neurologic examination. After weeks and months of examinations and tests with only partial results, he came home to the United States, to Roanoke, Virginia, where in just three days of literally space-age examinations the definitive and ultimate answer to his problem was easily, almost routinely, rendered.

We do have the best. But like it or not, public policy has become cost containment. This, too, is not all bad, but the danger is that the system is being increasingly driven by money. Such a system brings outside interests to play in decisions about patient care. It has always been assumed that the physician is the sole determinant of patient care decision-making. After all, the physician alone has the big picture, the necessary perspective. Sadly, this can no longer be assumed, and the physician-patient relationship itself is in jeopardy. For cost containment we now have HMOs, PPOs, standards of care set by prepaid providers, etc. We physicians are perceived as being self-serving when we hold that doctoring and physician-determined quality of care must drive the system.

I submit that even if we are imperfect in this, it is the only mechanism we can accept. After all, who else can be the patient's advocate? Insurance companies? Corporations? Business coalitions? Of course not! We must fill that role and work toward improving ourselves and a system that will allow it. We cannot give beyond a certain point on this, and the sanctity of the physician-patient relationship must remain inviolate. Also, we cannot ethically subscribe to any system which has built into it monetary incentives for the *withholding* of care and services. We, too, can be for cost containment but not at the expense of quality care. With us, this has to be the bottom line.

In this new environment we have become, sadly, a "marketplace" and are now "providers" offering services and products to consumers. As such, we are subject to all the parameters used to measure any other business arena. We are now on billboards, and we see TV ads extolling the virtue of things like laser surgery. To our dismay, the marketing of ourselves and our practices has become a fact of life.

The truth is that the providing and caring for sick human beings is not something to be sold like so much soap. It is, rather, a precious art, infinitely variable, always with unanswered questions and less than perfect answers. The doing of it is preceded by solemn oath, and although we approach it with a scientific mindset and discipline, we bring to it also heavy doses of compassion, awe and respect for that which we cannot understand. We need to set high standards and hold these up before the public, but let it be known that medicine is not an exact science, and things like service contracts and warranties are for toasters and copying machines, not people!

It is more and more difficult for us to take up the slack in a system that increasingly imposes outside controls and restrictions and at the same time demands the unrestricted best our present expertise can provide. We will try and do out best under whatever conditions we find ourselves, but we are obliged first to be patient advocates and therefore oppose any conditions or changes, managed care or otherwise, which are not in the patient's best interest.

As a small child I used to ride to and from hospitals with my father. On the front seat of his Buick there were instrument packs wrapped in cloth, medical journals, a leather bag filled with lights and blades and hammers, etc. I remember flicking the lens of his ophthalmoscope and wondering how anyone could learn to use such a thing.

Sometimes, during what seemed like interminable waits in the parking lot, I would press my face to the window and stare at the hospital, trying to find him passing a window or, better still, coming out the back door.

What could he be doing in there, and for so long?

One thing was certain: Whatever he was doing, it was definitely the noblest and loftiest thing a human being could do.

That remains true for all of us, and with that as a common bond in this 84th year of the Roanoke Academy of Medicine, we can and will easily proceed together.

Richard J. Grayson, Jr., MD

VIRGINIA MEDICAL OBITUARY

• **Edward Randolph Archer, MD,** Norfolk; Howard University School of Medicine, 1939; age 85; died May 17, 1989. He had retired from his practice as family physician and general surgeon.

• **Thomas McPherson Brown, MD,** founder of the Arthritis Institute at the National Hospital for Orthopaedics and Rehabilitation in Arlington; Johns Hopkins University School of Medicine, 1933; age 82; died April 17, 1989. Dr. Brown's autobiography, *The Road Back: Rheumatoid Arthritis, Its Cause and Treatment*, was published in 1988.

• **Allen M. Ferry, MD,** longtime orthopedic surgeon in Arlington; Johns Hopkins University of Medicine, 1938; age 76; died in Virginia Beach on April 10, 1989. Past president of both the Virginia Orthopaedic Society and the Northern Virginia Academy of Surgery, Dr. Ferry retired in 1971 because of ill health.

• **Forest G. Harper, MD,** Staunton; University of Virginia School of Medicine, 1936; age 76; died April 3, 1989, in Coral Gables, Florida. He was a radiologist at King's Daughters' Hospital, Staunton, for 35 years.

• **John P. Lynch, MD,** retired internist/geriatrist and past president of the Richmond Academy of Medicine; Medical College of Virginia, 1935; age 80; died July 15, shortly after he had written the Letter to the Editor that appears on page 298 of this issue.

• **James D. Mills, Jr., MD,** Alexandria; Washington University School of Medicine, 1950; age 68; died April 25 of acute leukemia. President in 1972 of the Alexandria Medical Society, Dr. Mills developed the so-called "Alexandria Plan" for emergency department staffing, which became a national model.

• **John Aldrich Stephenson, MD,** Lynchburg pediatrician; Case Western Reserve University School of Medicine, 1961; age 53; died unexpectedly May 14, 1989, of a cerebral vascular accident.

• **Joseph Edwin Warren, MD,** Lynchburg obstetrician/gynecologist; University of Georgia School of Medicine, 1938; age 73; died May 28, 1989.

• **William Lynn Wingfield, MD,** Richmond; Medical College of Virginia, 1937; age 76; died May 5, 1989. An internist, he taught at the Rheumatoid Arthritis Clinic at MCV and had been medical director of Virginia's penal system.

Memoir of Lloyd Burk 1916-1989

By Harry Clark Bates, Jr., MD

Dr. Lloyd B. Burk, Jr., a prominent Arlington, Virginia surgeon and civic leader, died March 24, 1989, of cancer. He had retired after 35 years of active practice, moving to Lake of the Woods in Locust Grove, Virginia.

Born in Texas, Dr. Burk moved to Northern Virginia in 1919, attended high school in Washington DC, and received his medical degree at the University of Virginia in 1942. After interning at Virginia Mason Clinic in Seattle, Washington, Dr. Burk went into a surgical residency at the University of Michigan.

Returning to Arlington, he began private practice in general surgery in 1947. Certified by the American Board of Surgery in 1949, he became a fellow of the American College of Surgeons in 1950.

Dr. Burk served as the first chief of general surgery (for six years) at Fairfax Hospital, and was a founding physician of Northern Virginia Doctors Hospital and a member of its board of directors. He was also an active member and trustee of Arlington Hospital for ten years. During this time he was assistant professor of surgery at both Georgetown and George Washington Universities.

Dr. Burk was president of the Arlington County Medical Society in 1953 and received its Welburn Award in 1957. From 1969 to 1972 he was vice president of the American College of Surgeons, Virginia Division. From 1969 to 1971 he held the post of president of the Virginia State American Cancer Society, receiving its Horsley Award in 1971 for "outstanding contribution to the control of cancer."

Active as a community leader, he worked in local school organizations, Virginia and Arlington health councils, and in his church. His actions played a large part in the development of the Arlington County Hotline and the Arlington County Career Center.

After retirement from active practice in 1982 he continued to function as a surveyor of cancer programs for the American College of Surgeons. In Locust Grove, he helped establish a new Optimist Club and worked hard in the development of a beautiful new church for the Lake of the Woods community. He actively sought help from local businessmen in the construction of a lighted baseball field, which has since been named in his honor, as well as an indoor sports complex.

Lloyd Burk is survived by his wife, Loise, a sister

Phila Bell Blackwell of Alexandria, and six children: Nancy Willis of Greensboro, North Carolina; Susanne Cleary of Friedberg, Germany; Sarah Goodrich and Carolyn Robinson of Lake of the Woods; Paul Burk of Alexandria; and Byron Burk of Charlottesville, as well as twelve grandchildren.

Lloyd spent his medical lifetime in conflict with cancer. He saved many, many lives through his expert surgery, and I frequently felt blessed to have his knowledge and ability available for my patients. He was a fine friend and one we will truly miss.

Memoir of Charles Troland 1911-1989

By Joseph F. Kell, Jr., MD, and William M. Eagles, MD

Dr. Charles Edward Troland was born in 1911 in Fredericksburg, Virginia, the son of a local merchant. He died on February 28, 1989.

Dr. Troland's early schooling was obtained at Fredericksburg in the public schools, and after graduation he enrolled in Hampden-Sydney College. After graduation from college he entered the Johns Hopkins School of Medicine, from which he graduated in 1936. He remained at Johns Hopkins for his internship as a house officer in surgery; Hunterian Fellow of Surgery, 1937-38; William S. Halsted Fellowship in Surgery, 1938-39; and assistant neurosurgeon, 1939-42.

Following his stint at Johns Hopkins he served in the U.S. Army Medical Corps, assigned to the China-Burma-India theater, and did neurosurgery in field hospitals. Before leaving the service he was assigned for a short time to the McGuire General Hospital, Richmond, where he was discharged from the service with the rank of major. He was appointed to the Medical College of Virginia faculty as assistant professor of neurosurgery and was elevated to full professor in 1952.

Dr. Troland was the author of numerous publications and together with Dr. Frank Otenasek edited and published *The Selected Writings of Dr. Walter E. Dandy*. This was a major contribution to the field of neurosurgery.

Dr. Troland was a member of all the major neurosurgical societies and of the Southern Surgical Association, which he prized very highly. He was also a member of the American Medical Association, The Medical Society of Virginia, the Richmond Academy of Medicine and the Southern Medical Association.

Teaching and working with his resident staff seemed to give Charles his greatest enjoyment and this can be attested to by both of these authors. He was a master surgeon in the operating room and was dearly beloved by his patients. The Richmond Academy has suffered from this loss.

Memoir of Louise Clark 1908-1989

By R. G. McAllister, MD, J. O. Burke, MD, and R. M. Phillips, MD

Dr. Louise Leland Clark died March 11, 1989, after a solo general medical practice of 43 years. She was 81 years of age and had retired in 1985.

Dr. Clark was born in Ithaca, New York, daughter of the late Professor and Mrs. Ora Miner Leland. Her father taught in the Engineering School of Cornell University. Her mother died was she was a very young girl. Louise earned her bachelor's degree in physical education at the University of Minnesota and taught for three years before getting her master's degree in physical therapy from New York University. She entered the Medical College of Virginia, graduating in 1937. While a student she participated in the establishment of the Physical Therapy Program there, a relatively new field of medicine at that time. She served her internship at MCV, and as assistant and resident in pediatrics at Maryland University Hospital. In 1939 she married Bruce Leslie Clark, a Richmond newspaper reporter, whom she met in the MCV emergency room while he was covering a traffic accident. He was killed in an automobile accident in 1948. Her younger son died at age 6, in 1951, when struck by an automobile.

In 1942 she began the private practice of medicine in Chester. She held clinics for the Health Department throughout Chesterfield County. She was very active in her community and St. John's Episcopal Church. She was a long-time supporter of the Order of St. Luke and Camp Farthest Out and had attended world-wide European conferences, at least once as a delegate. In 1968 she participated in a three-month mission to Africa sponsored by Church Women United. She served on the board of the Lucy Corr Nursing Home.

Beloved in her community, Dr. Louise Clark was the epitome of the complete family practitioner. Her patients adored her. She had great empathy and understanding. No effort for the patient's benefit was too

great or too time-consuming. She will be greatly missed.

She was a member of the Chester Women's Club, the Richmond Academy of Medicine, The Medical Society of Virginia, the American Medical Association, and the Virginia and American Academies of Family Physicians.

She is survived by a son, Cdr. Donald Bartlett Clark; two grandchildren, Leslie and Bruce Clark, of Corpus Christi, Texas; two brothers, Walter Leland of Minneapolis and Paul Leland of Marina Del Ray, California; and one sister, Mrs. Miriam Kahle of Kansas City, Missouri.

Memoir of Sanford Warshauer 1935-1988

By Jerome Stein, MD

The Alexandria Medical Community mourns the loss of Dr. Sanford Warshauer, who died from leukemia on November 1, 1988. Dr. Warshauer was known for his dedication to the Alexandria Hospital over the past 20 years and was influential in modernizing the obstetrical care at the hospital. He was a graduate of Cornell University in New York and the University of Glasgow Medical School in Scotland. He did his internship and residency in New York City and started his private practice of ob/gyn in Alexandria in 1968.

In 1968, obstetric delivery, for the most part, necessitated the use of anesthesia. Today, labor and delivery suites have changed to the commonly used Lamaze method of natural childbirth. Dr. Warshauer was a proponent of this type of prepared childbirth and was influential in encouraging the construction of the birthing center at Alexandria Hospital. He was the first obstetrician to perform a Leboyer delivery at the hospital, reflecting his "non-violent" approach to childbirth.

Dr. Warshauer was a past president of the Alexandria Hospital medical staff and past chairman of the hospital's board of trustees and remained on the medical board for several years. He was also active in the Alexandria Hospital Corporation and was on the staff of Mount Vernon Hospital as well.

He was a person who was never satisfied with the status quo. He wanted to see changes for improvement in whatever endeavor he undertook and had the courage of his convictions to carry out these endeavors. He will be missed by his colleagues, friends, nurses and family. Contributions in his memory are being earmarked for the Cancer Center presently being constructed at the Alexandria Hospital.

Memoir of J. S. Kitterman 1917-1989

By James M. Wolcott, Jr., MD, Henry G. Carter, MD, John R. Kight, MD, and Ralph J. Nold, MD

James Sidney Kitterman, MD, died on February 14, 1989, at the age of 72.

Dr. Kitterman was a native of Norfolk. He received his education at Maury High School and the University of Virginia, and his MD degree from the School of Medicine of the University of Virginia in 1940. He pursued postgraduate training at Harvard University and DePaul Hospital, Department of Surgery. During World War II, Dr. Kitterman served as a naval medical officer. He remained active in the Naval Reserve and retired with the rank of captain in 1976.

Dr. Kitterman entered private practice in Norfolk in 1950. He was on the staffs of DePaul Hospital, Norfolk General, and Leigh Memorial (Sentara) Hospitals. He served as president of the Norfolk Academy of Medicine and vice president and vice-councilor of The Medical Society of Virginia; he also held memberships in the American Medical Association and the Southeastern Surgical Congress. He chaired numerous hospital committees. Dr. Kitterman also held memberships in the Sons of the Confederacy, the Sons of the American Revolution, the Fraternal Order of Police Associates, and Goodwill Industries of Tidewater. He was a member and former vestryman of Christ and St. Luke's Episcopal Church.

He is survived by his wife, Margaret Bevilaque Kitterman; three sons, James S. Kitterman, Jr., of Portsmouth, John V. Kitterman of Virginia Beach, and William P. Kitterman of Louisville, Georgia; and four grandchildren.

Dr. Kitterman was well known for his zest for life. He was a loved and admired by his patients and respected by his medical colleagues. His ready wit and sunny disposition will be greatly missed by all who were fortunate enough to have shared a part of his life.

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continued over

Help for a troubled friend is only a phone call away.

If you suspect a colleague is experiencing problems with alcohol or drug abuse, don't contribute to the "conspiracy of silence," call The Medical Society of Virginia's Physicians' Health and Effectiveness Committee. A non-punitive approach through rehabilitation *is* an alternative. Your report will be kept confidential. Ask for Jeanne Douglas at MSV headquarters, (804) 353-2721.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

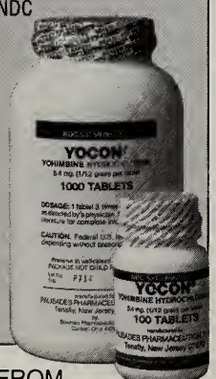
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



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On November 7, 1989, Virginians will elect all 100 members to the Virginia House of Delegates, Governor, Lieutenant Governor, and Attorney General. You, your spouse, and VaMPAC will determine how many of those elected will be oriented toward the views of medicine.

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Our strategy works. VaMPAC contributes to "friendly" legislators, avoiding partisan battles and concentrates on issues related to medicine. Because few legislators support or oppose us all of the time, and most will vary depending upon the issue, VaMPAC carefully avoids partisan identification and crosses party lines as needed to reinforce old friendships and seek new ones. Occasionally, such activities may offend your personal political orientation; the reality is that legislative success cannot be achieved without bipartisan support.

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Name _____ Spouse _____
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This is the Natural Death Act form authorized by the 1989 General Assembly. Save the page and photocopy it at will for use by your patients.

Physician's Guide to the Natural Death Act

From the time it became effective in 1983, the Natural Death Act (Virginia Code §54-325.8:1) has offered a statutory "safe harbor" for the Virginia physican who complies in good faith with its provisions.

The Act defines "terminal condition" as "a condition caused by injury, disease or illness from which, to a reasonable degree of medical certainty, (i) there can be no recovery and (ii) death is imminent."

"Life-prolonging procedure" is defined by the Act as "any medical procedure, treatment or intervention which (i) utilizes mechanical or other artificial means to sustain, restore or supplant a spontaneous vital function or is otherwise of such a nature as to afford a patient no reasonable expectation of recovery from a terminal condition and (ii) when applied to a patient in a terminal condition, would serve only to prolong the dying process; however, nothing in this act shall prohibit the administration of medication or the performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain."

These are the steps the law requires:

1. A patient makes a declaration directing the withholding or withdrawing of life-prolonging procedures in the event of a terminal condition. If the declaration is written, it must be signed by the patient and two witnesses, neither of which may be the patient's spouse or blood relative but one of which may be the physician.

If the declaration is oral, it is valid only (i) if made after the patient has been diagnosed as having a terminal condition and (ii) if it is made in the presence of a physician and two witnesses, neither of which may be the patient's spouse or blood relative.

2. If the patient has made a valid declaration and is competent, the attending physician must then certify in writing that the patient has a terminal condition before withholding or withdrawing a life-prolonging procedure.

3. If the patient has made a valid declaration but is "comatose, incompetent, or otherwise physically or mentally incapable of communication," the attending physician must certify in writing that the patient has a terminal condition and must also have one other physician examine the patient and do likewise before withholding or withdrawing a life-prolonging procedure.

4. In the case of a patient who is comatose, incompetent or otherwise physically or mentally incapable of communication and who has not made a written or oral declaration, the Act designates these persons, listed in order of priority, with whom the attending physician must consult and agree prior to withholding or withdrawing a life-prolonging procedure:

1) any guardian or committee judicially appointed on behalf of the patient;

2) anyone designated in writing by the patient to make the treatment decision;

3) the patient's spouse;

4) an adult child of the patient or a majority of the children who are reasonably available for consultation;

5) the parents of the patient;

6) the nearest living relative of the patient.

If no one in the first category is "reasonably available, willing and competent to act," the physician may go to the next priority, and then the next, until an appropriate person is located.

But when the physician must turn to any of the family members in the last four categories, the physician (i) must insure that there are two witnesses present when the treatment decision is made with those family members, and the patient's spouse and blood relatives may not serve as either of these witnesses, and (ii) must get consent from two persons in any of the last four categories if two are reasonably available.

Two points should be emphasized. First, the Act does not apply to patients who are under 18 years of age. Second, if a physician does not want to direct the withholding or withdrawing of life-prolonging procedures as authorized by this Act, he has no obligation to do so; he must, however, offer to transfer the patient to another physician.

The Act does not eliminate any immunity a physician already may have under the common law.

Attorneys Sandra Kramer and Allen C. Goolsby III developed this legal information for the June 1983 issue of Virginia Medical. *It has been slightly revised for subsequent reprintings.*

VIRGINIA'S NATURAL DEATH ACT

Virginia's Natural Death Act was enacted in 1983 (Virginia Code 54.32.8:1) to permit Virginians to record their wishes regarding extraordinary care in the event of terminal illness. The declaration below is the legal instrument developed by the state legislature to implement the Act. Fill out this form and give it to your physician and any relatives and friends you would like to have a copy. You must sign in the presence of two witness, and both witnesses must sign in your presence. Blood relatives or spouse may not be witnesses.

DECLARATION

Declaration made this_____day of_____(month, year.) I, _____ willfully and voluntarily make known my desire and do hereby declare:

You must choose between the following two paragraphs. The one on the left designates a person to make a decision for you. In the one on the right, you make the decision. Cross through the paragraph you do NOT want.

If at any time I should have a terminal condition and my attending physician has determined that there can be no recovery from such condition, my death is imminent, and I am comatose, incompetent to otherwise mentally or physically incapable of communication, I designate_____ _____ to make a decision on my behalf as to whether life prolonging procedures shall be withheld or withdrawn. I wish to be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, care or to alleviate pain.

If at any time I should have a terminal condition and my attending physician has determined that there can be no recovery from such condition and my death is imminent, where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort, care or to alleviate pain.

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

(Signed) _____

The declarant is known to me, and I believe him or her to be of sound mind.

(Witness) _____

(Witness) _____

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LETTERS

The Directory: Perfection Is Elusive

I have just received my 1989 Directory of Virginia Physicians. It is a fine publication and certainly was a big job to do.

However, it does not really fill my needs. I frequently see patients for general workups who live many miles away, and they are constantly asking me for the names of good physicians in their hometowns. What I need is a geographical listing as was contained in the Roster of Practitioners put out by the Virginia State Board of Medicine, last edition 1982.

In your 1990 edition will you give some consideration of this very necessary addition? For reference, the University of Virginia Medical Alumni Directory also has it by geographical location as does the American Society of Internal Medicine and of course the several larger publications, such as the Directory of Certified Internists and the Directory of Medical Specialists.

Robert B. Ooghe, MD
Suite 1-A, 505 Faulconer Drive
Charlottesville VA 22901

THE EDITORS regret that a planned geographical listing for exactly the purpose Dr. Ooghe describes was abandoned because of cost. We will renew efforts to incorporate it in a future edition.

We thank all those who used the furnished postcard inside the Directory's cover to notify of changes in address/phone/specialty, and we are sorry their entries are imperfect as printed.

Very upsetting indeed are some inexplicable omissions affecting the entries of Medical Society of Virginia members. The names of Dr. John P. Franko, Danville, and Dr. Robert S. Brown, Jr., Charlottesville, are nowhere to be found, and we deeply regret their absence. Also mysteriously missing is the specialty entry for Dr. Alexander D. Crosett, Jr., Kilmarnock, who holds distinguished credentials as a diagnostic radiologist.

As for the "Nuclear Surgery" designation ascribed to 74 fine physicians who practice neurological surgery, we are profoundly grieved by this "formidable error," as Dr. Berkley L. Rish of Norfolk quite rightly terms it, and apologize wholeheartedly to these neurological surgeons.

Is a directory ever perfect? Probably not, but we hope to come closer to it next time.

BOOKS

Jury of My Peers: A Surgeon's Encounter with the Malpractice Crisis, by Howard C. Snider, Jr., MD. Montgomery, Alabama, Fountain Press, 1989, 292 pages, $19.95.

All of us were taught that one of the benefits of living in the United States is the right to a trial by a jury of our peers. Guaranteed in the Constitution, trial by jury in criminal matters was another step forward from the oppression and capriciousness of divine-right sovereigns and English jurisprudence. Readers may be surprised to learn that the Constitution allows for jury trial only in criminal offenses. It took the Seventh Amendment to expand trial by jury to civil matters that exceeded $20 in value.

The major point Dr. Snider relates to us in this short but gripping real-life nightmare with a medical malpractice suit is how poorly prepared a lay jury is to hear and decide upon the merits of a medical case. We see in vivid detail how the plaintiff's attorney, even though ill-schooled and ofttimes ignorant of basic anatomy and physiology, can influence the jury with well-placed questions designed to develop compassion for the plaintiff and to accentuate the plaintiff's pain and suffering. The case is one that Dr. Snider and his senior partner became involved in due to their surgical success. They saved the life of a young woman referred to them with recurrent cancer of the colon by performing a pelvic exeneration. Both intra- and postoperative complications occurred, but neither of these was due to poor care. The patient recovered within two months, and five years later (at the time of the trial) she was alive and quite functional. Had she died of her disease, the surgeons might have received a card of thanks from her family. By surviving, the physicians were an easy mark for their former patient.

Every physician or physician-in-training should read this book. In fact it would be a good idea for lawyers and legislators to read it also. Our current tort system is patently imperfect. Suits are settled not for what is right but for what is expedient. Good physicians are caught up in a tort system over which they have little control. Judges, lawyers and insurance carriers are the major players in this arena, with the physician as the only one with a long-term stake in the action and little voice in the outcome.

Dr. Snider raises his voice in this well-written book. He captures the feel of the courtroom, the tenseness of the proceedings and the helplessness of the defendants. His writing style keeps the reader in suspense until the last moment when the jury returns to the courtroom and the verdict is read. What is even more surprising than the verdict is the post-trial interview with certain jury members. Here we gain a view into an otherwise unknown area—the process by which a lay jury reaches its decision. To me, it was frightening. This final chapter clinches Dr. Snider's argument regarding the weakness of the lay jury system in deciding medical malpractice cases. If you did not fully appreciate the unfairness of the civil tort system in medical cases before reading this book, you will be when you finish the final chapter.

Barry V. Kirkpatrick, MD

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Richmond VA 23226

Jury of My Peers *is available only from the publisher, Fountain Press, at PO Box 11621, Montgomery AL 36111. To the price quoted above add $2 for postage.*

Hello, Friend, Stories of Dr. George B. Craddock, Sr., compiled by Jeffrey Wilson, MD. Lynchburg, Virginia, Warwick Publishing, 1989, 50 pp, $6.

Jeff Wilson chose a splendid way to keep the memory of George Craddock alive and dear for us. Not with a cold, structured curriculum vitae or a carefully numbered bibliography, but with a group of poignant vignettes of his life. All of which pointed to his sincere interest and concern for people in general, and his patients in particular. His intense interest in all phases of medicine, but internal medicine especially, served as his medium for activating this interest and concern.

The monograph is rife with examples of his interest and concern in patients and his medical expertise. A few that struck my attention:

- The devotion developed in the care of a college professor's wife who had fatal Boeck's sarcoid.
- The search for and discovery of an elderly patient who had fallen in the snow and fractured her hip.
- His gift of $600 to a family with a sick child when they were being sent to a strange city.
- His medical relationship with the gypsies in the area. I would have enjoyed being a fly on the wall when he attempted to get a history from these secretive people.

Lest one draw the opinion that George was solely a paragon of intensely serious work and grim determination, be aware that he had a keen sense of humor, a wide range of anecdotes of quiet humor, and an encyclopedic knowledge of baseball. He not only knew the present and past performance of big league stars but could tell you the current batting average of the third baseman of Peoria in the Three Eye League.

Elam Toone, MD

4402 West Franklin Street
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Commentary: Physical Fitness and the High School Athlete

As a natural result of the ascendancy of organized sports at both professional and collegiate level, sports medicine has evolved as a major medical specialty. Lagging somewhat in organization has been the medical evaluation of the high school athlete.

The accompanying article by Dr. Vito Perriello and his coauthors is an attempt to provide a definitive approach to the evaluation of the physical fitness of the high school athlete. His material is presented well, and there seems to be general agreement as to the concept; however, there is not universal support for the proposed method.

Reviewers have voiced these criticisms: The examination is too elaborate, time-consuming, and creates an unwarranted expense. Presently, many of the evaluations are performed without charge by the physician; in the majority of instances the charges are minimal. Someone will have to bear the increased expense.

The evaluation is too elaborate. For example, the good clinician rarely needs special studies to determine whether or not the candidate is too fat. Nor is the maturation evaluation usually necessary. Further, laboratory studies such as hemoglobin and urinalysis are not often productive. A stress test is unwarranted as a routine procedure.

The usual history and physical examination of the high school athlete requires five to ten minutes. The good clinician will recognize a borderline case and the evaluation of that candidate will require extra procedures, perhaps a stress test.

One reviewer has praise for the expanded history section and the form seeking parental permission for emergency treatment of the injured athlete. However, that same reviewer feels that the old method of history "checks" is more suited to the busy practitioner. Further, any procedures listed on the form and not included by the physician on a particular examination might provide material for an aggressive malpractice attorney.

The authors have answers for these criticisms. They note that the exam can be performed in the 15 minutes usually allotted to the pediatric patient. They feel that the maturation test, requiring only a brief moment of inspection, is important, but the laboratory procedures can be omitted. Further, they say, the stress test as performed under their guidelines is simplistic and requires only two or three minutes. Finally, in response to the implied legal dangers resulting from the omission of listed procedures, they point to the fact that pediatricians habitually omit rectal and vaginal examinations, noting only "not done."

Dr. Perriello and his associates are to be congratulated on their efforts to protect the young athlete by providing a more complete examination. It may be that some modification will be required, but the present study does provide a definitive move toward improvement in the evaluation of the high school athlete.

E.L.K., Jr., MD

VIRGINIA
MEDICAL
SEPTEMBER 1989

New Medical Standards for Virginia's High School Athletes

Vito A. Perriello, Jr., MD, John T. Benjamin, MD, Michael D. Dickens, MD, Raymond F. Ford, MD, Charles H. Gleason, MD, David L. Hawkes, MD, Charles W. Machen, MD, David N. Reynolds, MD, and Thomas Schildwachter, MD, *Charlottesville, Virginia*

Virginia physicians administering preparticipation physicals to high school athletes this fall are using the new, expanded examination form that appears in this issue. Representing multidisciplinary input and incorporating current sports medicine information, the form is designed to identify the student at high risk for injury and to evaluate for a specific sport. After a two-year pilot program conducted by the authors, the new form was officially adopted by the Virginia High School League.

An increase in athletic participation by Americans of all ages and capability levels, the addition of new sports and more female athletic teams at Virginia's schools, and an increased interest by the medical community in the special problems related to sports participation have stimulated research and generated much new information in the field of sports medicine. As a result, states all over the country are taking steps to improve the athletic preparticipation forms used by physicians to assess the fitness of adolescents who wish to enter athletic activity in their schools. The revised and expanded form adopted early this year by the Virginia High School League (VHSL) places Virginia in the forefront of that movement.

Virginia currently has 281 public and 75 private high schools. The Virginia High School League supplies athletic preparticipation forms to all of them. In its previous format, which had not been changed in many years, the supplied form did not adequately address the areas most likely to identify a student at high risk for athletic injury nor did it provide for a sport-specific evaluation. Additionally, the old form did not ask for sufficient past and family history, adequate orthopedic examination, or a measurement of physical maturation and condition. In many instances, the resultant physical served only to satisfy the administrative or legal requirement with a cursory examination that gave a false sense of security about the health and fitness of the examined student-athlete.

All but one of the authors are in private practice together as Pediatric Associates of Charlottesville. Dr. Schildwachter is an orthopedist in private practice. Address correspondence to Dr. Perriello at 1011 East Jefferson Street, Charlottesville VA 22901.

Submitted 7-6-89.

Changes in the Form

The new form was adopted after being tested on over 500 students during a two-year pilot program. Four pages in length instead of the

Doctors, Trainers Share New Committee

Concurrent with the adoption of its new athletic preparticipation form, the Virginia High School League's board of directors established a Sports Medicine Advisory Committee comprised of physicians and athletic directors/trainers. Dr. Vito A. Perriello, Jr., MD, pediatrician in private practice in Charlottesville and lead author of the accompanying article, was elected chairman. Larry W. Johnson, the VHSL's supervisor of boys/officials programs, was selected as secretary. These were appointed as Committee members:

- Timothy Bane, athletic trainer, Patrick Henry High School, Roanoke;
- Stephen P. Bolduc, MD, pediatrician in private practice in Newport News and chairman of the Sports Medicine Committee of the American Academy of Pediatrics;
- Nancy C. Burke, athletic trainer, South Lake High School, Reston;
- Steven L. Cole, director of sports medicine, College of William and Mary, Williamsburg;
- Joe H. Gieck, head athletic trainer, University of Virginia, Charlottesville;
- Marriott C. Johnson, Jr., MD, orthopedist in private practice in Fredericksburg;
- James L. Jones, athletic director, Stafford High School, Roanoke;
- Frank C. McCue III, MD, director of sports medicine and hand surgery and team physician, University of Virginia, and chairman, Sports Medicine Committee of the Medical Society of Virginia;
- Bruce M. Patrick, coordinator for student activities and driver education, Fairfax County Public Schools, Annandale;
- Michael J. Petrizzi, MD, family practitioner in private practice in Mechanicsville.

previous two, it leads off with the old form's Part I (rules and demographics) and Part II (parental consent) with only some minor changes in language as suggested by legal counsel.

Part III is a new section, dealing with parental consent for emergency treatment; this section permits a physician to administer emergency treatment when parents of the injured child cannot be reached. The benefits of this section are obvious, and it is hoped that the schools will be diligent about making sure this section is completed and that coaches and trainers carry these sections with them wherever the team goes.

Part IV seeks historical data, as in the old form, but has been expanded to incorporate questions aimed at identifying youngsters with high-risk factors. This section reflects the recent literature about significant risk factors.[1–6] Needless to say, the physician must spend some time reviewing this section with the student if it is to be meaningful. Our experience with the pilot program led to a policy requiring completion of the history part, including parental signature, before we would perform the physical examination, and we recommend doing it that way.

The physical exam itself appears as Part V. It includes the traditional elements of a well checkup exam, plus a few sport-specific items. A new inclusion is the Tanner Stage or Maturation Index. Reports of the dangers of prepubertal youngsters competing with postpubertal athletes in collision sports[6–7] led to this inclusion; in fact, basing a sports participation recommendation on maturational status has been said by Dr. Nathan Smith to be the single most effective step in reducing risk in sports.[8] We elected to use the Tanner staging method because it is quick, easy and requires no additional equipment. (Illustrated charts explaining the Tanner method are included in the informational kit offered with this article.) An alternative method for determining maturation index, and a popular one, is the grip strength measure, which, however, requires the purchase of a spring dynamometer.[9]

The percent body fat and pulse entries in the physical exam part of the form represent an attempt to assess both nutrition and fitness.[10] A body fat of over 20% in boys and 25% in girls is reason for attention. Body fat measurement is also helpful in sports such as wrestling. Many tables are available utilizing various body areas to determine body fat.[11,12] We follow the recommendations of Jackson and Pollock[13] for measuring triceps, chest and subcapsular area in males and triceps, abdomen and suprailium in females. The kit offered with this article includes an illustrated guide to body fat measurement and tables of percent fat estimates for men and women, with desired weight ratios. After studying this information a physician should be able to perform the percent body fat procedure in less than a minute. Fat calipers can be purchased from a medical supply firm or obtained free of charge from some drug companies.

Exercise testing is included in the form to assess the cardiovascular condition and to screen for significant arrhythmias, subtle murmurs, etc. We had difficulty finding standardized values for fitness in this age range that were practical for large groups; the step test, treadmill and Vmax test require either too long a period of exercise or expensive equipment. So we combined Galioto's[14] use of two minutes of jumping jacks and recovery to listen for subtle murmurs and the work of Washington et al[15] on school children 7 to 13 years, looking at changes and recovery in pulse rates, to devise our test for fitness. We

found the following to be a practical approach: taking a resting pulse, doing 2 minutes of jumping jacks (one-per-second rate), measuring the pulse 1) immediately after and 2) again after a one-minute recovery period. Although we need to analyze our data more thoroughly, it appears to us now that a rise of greater than 95 beats/min or a drop after a one-minute recovery period of less than two-thirds of that rise would be above the 95th percentile, raising concerns about fitness.

The form also places new emphasis on the musculoskeletal exam because of reports[1] that the most common significant physical finding at this age involves 1) previous injury or 2) asymmetry, weakness or lack of flexibility—any of these predisposing to athletic injury. The kit offered to you with this article includes a copy of a monograph demonstrating a quick and relatively comprehensive orthopedic screen.[16]

The last item on the physical exam is a blood test for hemoglobin and iron stores. There is always debate as to whether laboratory work is necessary. Our experience indicates that the sports physical is the only physical exam received by over 50% of Virginia youngsters from the time they are given a prekindergarten checkup through high school. Recent studies have shown that abnormal free erythrocyte proporphyria (FEP) levels, even with normal hemoglobins, may affect athletic performance.[17] Thus it is worthwhile to include the urine and hemoglobin.

Finally, the form encourages the physician to be specific and detailed about what the athlete's participation should and should not be by offering considerable space for recommendations and the reasons behind them.

Over all, we found that information about their physical condition was very interesting to the student-athletes we examined and was a good predictor of which of them needed preseason conditioning and/or monitoring during the hot days of early fall practice. Ideally, these physicals should be performed well before practice starts in order to identify those athletes who need conditioning.

Administering the Examination

This examination can be administered by whatever method the physician and/or the school system finds most practical. A few of the 500+ physicals we performed for the pilot study were done in our private pediatric office. We found that once the physician becomes efficient at the evaluation, the exam can be completed in the 15-30 minute time slot typically allotted for such a check up.

Most of our exams, however, were made by scheduling groups of students for examination at their schools, or our office and utilizing a 7-station method, as follows: 1) check in/check out; 2) height/weight/urinalysis/blood; 3) vision/hearing; 4) BP/pulse; 5) HEENT/heart/lungs/maturation/body fat; 6) orthopedic function; and 7) review of history and findings. If you order the kit offered with this article you will receive a copy of the check list we used with this method. Since the completed form goes to the school, this completed check list, including the physician's recommendations regarding sports participation and general health, can be sent to the parents.

The two schools cooperating in the pilot program were Western Albemarle High School, a public school, and St. Anne's-Belfield, a private school. Groups of 10-15 students were scheduled through the athletic director's office at 30-minute intervals. When they made their appointments, the students were given copies of the form's history section and told that it must be completed, signed and brought to the appointment or the examination would not be given. Some groups were scheduled immediately after school, some at night.

We usually had two station 5s and two station 7s, with a physician at each station. Most of the time we used an orthopedist at station 6. Nurses and/or trainers were used at the other stations. The review of history and resultant discussion of health matters at station 7 was considered the most important element in making the examination meaningful. With the staffing as described, we were able to do 25-30 students per hour.

We gave a sheet of "Sports Health Tips" to each student, and, for the professionals at the stations, we developed an instruction sheet and a form to check off abnormal findings for data collection purposes. Copies of all of these are included in the kit offered on page 362.

Discussion

The new VHSL form is the result of four years of work and consultations with many physicians and educators. It appears to be more in agreement with the recent recommendations of the Sports Medicine Committee of the American Academy of Pediatrics,[18] but as professionals gain experience with it, there will undoubtedly be suggestions for improvement. Much work is yet to be done in analyzing data, monitoring and comparing injury rates, etc., to see if we can enhance the safety factor.

We acknowledge that a form neither guarantees nor prevents a comprehensive preparticipation evaluation. We further realize that at first glance the form may seem complicated, even overwhelming. However, after reviewing the literature and accumulating a tremendous amount of data and experience, we feel that this new form is practical to administer and that the items included are important to reduce the risk of injury to Virginia's adolescent athletes.[19] We also feel the new form affords the health professional an opportunity to emphasize to a youngster the importance of fitness, nutrition and other measures significant in minimizing injuries and maximizing the joys of sports participation.

Controversy continues about whether the sports physical should be a comprehensive health maintenance examination or a sport-specific evaluation, whether laboratory tests should be included, and how

frequently the exam should be required.[20,22] There also are pros and cons concerning whether the administration of the examination is best performed by the student's primary physician in his/her office or by a group of multidisciplinary professionals in a station format.[23]

Then there is the growing consensus that a sports physical is not needed every year. Feinstein's survey[24] showed that 35 states still require yearly physicals. During our pilot program we required the comprehensive examination only every other year. On the year a physical was not required, the student filled out an interim report. The school nurse or trainer measured height, weight and blood pressure, and a physician in our office reviewed the form with the trainer or athletic director. If no significant change was found in the student's status, he or she was approved for the same participation recommended at the time of the full checkup. If a significant change in health status had occurred, a repeat exam was ordered, but we found this necessary in only a few instances. Usually a check by the trainer, a note from the treating physician confirming readiness for participation, or a quick check of a reported injury or illness enabled renewal of approval. If, in the second year of the pilot program, an athlete not recommended the previous year for a collision sport renewed the request to enter that activity, reexamination was recommended to assess the level of maturation. Similarly, if a weight gain of more than 10% without a commensurate increase in height had occurred in a student, a second-year repeat physical, either partial or complete, was recommended. We hope that an interim report will soon be an option available to those schools or physicians who want to use the every-other-year physical. Meantime, if you send for the offered kit, you will find a copy of the interim evaluation form we developed for the pilot program.

The two questions most frequently asked by physicians about

Physician's Kit for the New VHSL Physical Exam

Available for Medical Society of Virginia members to order are kits designed to help physicians administer the new Virginia High School League physical exam. The kits are free and include all the charts, tables, and other informational material described in the accompanying article, as follows:

1. Tanner Stage: Illustrated charts showing the progression of pubertal development in males and females.

2. Body Fat: Illustrated reprint on how to measure skinfold fat and tables of percent fat estimates for men and women.

3. Participation in Competitive Sports: American Academy of Pediatrics criteria for various categories of sports.

4. Health Tips: Examples of information for athletes to emphasize the importance of health in sports.

5. Orthopedic Examination: Reprint of a how-to monograph by Dr. Nathan Smith and the American Academy of Orthopedics.

6. Station Method: Guidelines for a seven-station physical, with descriptions of what is to be done at each station and a check-list to be retained by the student.

7. Interim Evaluation: Form to assess status of athlete when comprehensive physical is done only every two years.

To receive a kit, fill out and mail the coupon below. Orders will be taken as long as supplies last.

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the new form relate to enforcement of the recommendations and completion of the exam.

One, Will the Virginia High School League "stand behind" a physician's recommendation made on the basis of this exam? For example, if a physician recommends that an athlete not participate in a collision sport, will the VHSL enforce that recommendation? The answer is No. The parent and child have the final right to decide whether or not the youngster will play. However, if they elect to overrule a recommendation, they must acknowledge an understanding of the recommendation and a desire to participate in spite of it. This can be done in a letter to the school administrator or school board.

Two, Must everything on the form be completed? The answer to this question lies with the examining physician, for the physician always has the prerogative to complete or not to complete specific items in a physical examination form. For example, physicians often indicate "not done" on the pelvic and rectal exam entries in forms of this kind. It is up to the physician to decide what he/she feels is germane to the assessment of the individual's risk in participation. This school is interested only in the recommendation at the end of the form. In our opinion, however, each full completion of the new form will be an important increment toward healthier, more injury-free sports programs in Virginia's schools.

A major benefit of the efforts expended in developing the new form is the formation by the VHSL of the medical advisory committee whose members are listed on page 361. This committee was involved in the final stages of the new form's creation and should be a good sounding board for future suggestions relating to medical matters and sports in Virginia's schools. Any comments or suggestions can be sent to the committee at PO Box 41, Charlottesville VA 22902.

Summary

The new Virginia High School League preparticipation athletic form represents the consensus of physicians of many disciplines and incorporates the latest sports medicine literature and recommendations. Its major purpose is to identify student-athletes who are at high risk of injury, to propose preparatory or rehabilitative measures to prevent injury, and to direct youngsters to appropriate sports, rather than exclude them from participation.[1] A knowledge of sports and their physical demands and an awareness of the growing athlete's strengths and weaknesses—both are necessary for the physician to make appropriate and effective recommendations for sports participation.

The authors thank the board of directors of the Virginia High School League for its receptive posture and progressive thinking and express special appreciation to Earl S. Gillespie, Executive Director, and Larry W. Johnson, Supervisor, Boys/Official Programs. We are very grateful, too, to the administrators at Western Albemarle High School and St. Anne's-Belfield School, especially the athletic directors, Jaime Brown and Doug Tarring, for their cooperation and enthusiastic support in making the pilot program possible.

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The practice of medicine is a dynamic, ever-changing art witnessing new techniques and therapies on a constant basis. Nowhere is that more apparent than in recent changes in the management of renal and ureteral calculi. Prior to the early 1980s the surgical management of stone disease had been confined to open removal or blind manipulation of distal ureteral stones. However, within a span of three years technological advancements completely changed the management of renal calculi. Percutaneous access to the kidney was reported in 1955[1] but waited 20 years for technology to develop the instrumentation to remove stones via this approach. Within a few years surgeons were removing the largest, most difficult stones with this approach.[2] Technology now also offered visual access to the ureter via the bladder, appropriately called "ureteroscopy," which quickly offered access to stone removal in the ureter.[3] While these techniques were being mastered, development was underway for a machine which would fragment stones in the urinary tract extracorporeally.[4] This technique, called extracorporeal shock wave lithotripsy (ESWL), became available in the United States in 1984[5] and was quickly applied to both renal and ureteral calculi.[6,7]

The symptoms of urinary calculi remain unchanged, but these new developments have markedly changed the patient's options when confronted with a urinary calculus, as well as the surgeon's decision-making. We reviewed the surgeries performed for renal or ureteral calculi over a six-year period to determine the degree of change that has occurred in practice management of stone disease.

Materials and Methods

We reviewed six common surgical procedures performed between November 1982 and January 1989 to remove urinary calculi. These included cystoscopic stone manipulation and basketing, ureterolithotomy, ureteroscopy and stone extraction, pyelolithotomy, percutaneous nephrolithotripsy, and ESWL. These procedures were performed at multiple hospitals in the Richmond area by board-certified urologic surgeons. The three new, less invasive procedures were introduced into practice by these surgeons as follows: percutaneous nephrolithotripsy in February 1984, ureteroscopy in November 1984, and ESWL in January 1987. The time periods reviewed were selected so that the effect of each new technology as introduced could be determined. The time periods were divided into three sets: November 1982 to November 1984; December 1984 to December 1986; and January 1987 to January 1989. The number of procedures were determined and the number of cases per year calculated. The symptoms and circumstances that prompted surgery were reviewed for each procedure. Special attention was given to the changes in the application of open surgical procedures with the availability of less invasive procedures.

Results

The results are presented in Table 1. Of note is the marked decrease in open surgical procedures (i.e., ureterolithotomy and pyelolithotomy) with the introduction of less invasive techniques. The total number of patients evaluated and treated has increased over this time period. Of note also is that as each new technique was introduced there was a marked decrease in the number of invasive procedures performed in that situation. The number of ureteral lithotomies performed as treatment for ureteral calculi steadily decreased over the study period. This invasive procedure could be avoided by endoscopic stone-basketing, which was attempted on all small stones below the iliac vessels (42 per year). With the development of ureteroscopy the success rate of basketing lower stones improved. Thus ureteral lithotomy was seen to decrease further in application (four per year). In the eight patients who underwent ureteral lithotomy between January 1987 and January 1989 other procedures were attempted initially. In six of the eight patients, attempted endoscopic manipulation, either ureteroscopy, percutaneous nephroscopy, or ureteral stent placement had failed. The other two patients had midureteral calculi larger than 2 cm, one of which had been in the same location for two years. Both of these patients had skeletal deformities making ESWL impossible. Three patients presented with sepsis. Complications in this very high-risk group of patients consisted only of an incisional hernia.

Renal calculi are most often treated by pyelolithotomy, percutaneous nephrolithotripsy, or ESWL. We treated only large, symptomatic calculi by open surgery. With the practice of percutaneous nephrolithotripsy the number of nephrolithotomies decreased but then remained fairly constant with the introduction of ESWL. The pyelolithotomies performed were done because of inability to gain access for percutaneous

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nephrolithotripsy or obstruction at the ureteral pelvic junction, precluding passage of stone fragments and limiting urine drainage. Fortunately, there have been no complications in these few cases of pyelolithotomy (Table 2).

Discussion

Endoscopic and extracorporeal calculi manipulations have been great advances in stone treatment, but like their predecessors, the open surgical procedures, they are not without risks and complications. As with all stone surgery the calculi may elude the surgeon's grasp. This can happen regardless of the surgical approach, but good preoperative judgment as to the procedures best suited for the particular situation and mastery of all techniques will decrease this occurrence.

Complications of open surgery include bleeding, urine leakage, ileus, and those commonly associated with other types of open surgery; complications of endoscopic surgery and ESWL include many of these as well as others unique to each procedure. Ureteroscopy can result in perforations of the ureter, which can lead to urinary extravasation and stricture formation.[8] Indeed, two of our patients who had ureteral lithotomy had ureteral perforation at the time of ureteral manipulation. Fortunately, most patients can be managed endoscopically in the face of ureteral perforation and do not require open surgery. Bleeding is not a problem with ureteroscopy and these procedures are done routinely on an outpatient basis or with short hospital stays, which is an obvious advantage over ureteral lithotomy.

Percutaneous nephrolithotripsy is less invasive than open surgery but is subject to many of the same complications. This procedure is also limited by the

Table 1. Procedures Performed Per Year for Renal/Uretral Calculi (1982-1989).

Time Period	Ureterolithotomy	Stone Basketing	Ureteroscopy**	Pyelolithotomy	Percutaneous Nephrolithotripsy*	ESWL***
11/82 to 11/84 (2 years)	31	42	—	11	18	—
12/84 to 12/86 (2 years)	12	38.5	92.5	2.5	50	—
1/87 to 1/89 (2 years)	4	16.0	102.5	1.5	17	161

* Introduced February 1984 ** Introduced November 1984 *** Introduced January 1987

Table 2. Patient Data, Ureteral Lithotomy or Pyelolithotomy, January 1987–January 1989.

Age/Sex	Stone Size, Location	Medical Condition	Initial Procedure	Outcome
		URETERAL LITHOTOMY		
68/F	12mm Upper third	Sepsis, solitary kidney	Failed ureteral stent	Successful ureteral lithotomy
77/M	10mm Upper third	Blind, diabetes, confusion	Ureteral stent perforated ureter; patient pulled out percutaneous nephrostomy tube, sepsis	Successful ureteral lithotomy, placement of double J ureteral stent
68/M	11mm Upper third	Sepsis, neurogenic bladder, spinal injury	Unable to place ureteral catheter	Successful ureteral lithotomy, developed incisional hernia
86/M	10mm Mid third	S/P CVA with NGB, disoriented, sepsis	Unable to pass ureteral catheter or place percutaneous nephrostomy	Successful ureteral lithotomy
53/M	10mm Mid third	Bilteral calculi	Unsuccessful ureteroscopy, unable to bypass stone with stent: fever	Successful ureteral lithotomy
73/F	5mm Mid third	Severe arthritis, joint replacements, steroid dependent	Unable to bypass stone (in same location 2 yrs)	Successful ureteral lithotomy
61/M	8mm Mid third	Fever, pain	Stent retracted up ureter, ureteroscopy failed	successful ureteral lithotomy, urine drainage from wound resolved without treatment
59/F	25mm Upper third	Infection, bilateral calculi	Failure ureteroscopy, failed ESWL	Successful ureteral lithotomy
		PYELOLITHOTOMY		
60/M	Staghorn Kidney	ø	Percutaneous attempt, severe bleeding	Successful pyelolithotomy
42/M	40mm Kidney	Obesity	Unable to focus for ESWL, unable to place percutaneous nephostomy	Successful pyelolithotomy
38/F	Staghorn Kidney	Ureteral pelvic junction obstruction	Unable to pass ureteral catheter	Successful pyelolithotomy, pyeloplasty

ability of the surgeon to gain percutaneous access to the kidney.[2] Significant bleeding can occur during this procedure, as in one patient reported here in whom pyelolithotomy was performed to control hemorrhage and remove the calculi. Many calculi which previously would have been removed by percutaneous nephrolithotripsy are now treated by ESWL. Thus only the large staghorn calculi or radiolucent stones are usually treated percutaneously, and these more difficult stones are associated with greater risk of complications.

Extracorporeal shock wave lithotripsy is the least invasive of all the procedures described. With ESWL the stone is fragmented and the pieces must be passed spontaneously by the patient. In 60–80% of the patients the stone fragments pass, but on occasion they can be the source of complications. For instance, when a large amount of newly created stone sand moves into the patient's ureter, obstruction can occur and can result in pain, fever, and possible loss of kidney function if not identified and corrected. If these stone fragments do not pass rapidly they can be removed ureteroscopically or a tube (either ureteral stent or nephrostomy) can be positioned to drain urine while awaiting passage of the stones. Stones larger than 1.5–2.0 cm are more likely to result in ureteral obstruction after fragmentation. For these patients a ureteral stent may be placed or percutaneous nephrolithotripsy performed prior to ESWL. Unfortunately, not all stones are fragmented by ESWL and those composed of cysteine, which are difficult to see on x-ray, or located in the ureter are less likely to respond. Depending on the circumstances, when ESWL fails to result in a stone-free patient, it may be repeated or other endoscopic approaches employed to remove the calculi.

Whenever new technology is introduced into a field it takes time to determine its place in the practical management of the patient problem. Many factors, including effectiveness, patient safety and comfort, and cost, must be considered. For the management of renal and ureteral calculi in our practice, slightly less than 3% of our patients now require open surgical procedures, and we feel there will always be circumstances when open surgery will be the indicated and appropriate treatment. However, technological advances will lead to improved instruments, such as lasers to fragment stones and smaller instruments to provide access more easily and with less trauma to the ureter and kidney, and lithotripsy free of the need for anesthesia will soon be widely available, expanding the safety and application of ESWL. All these advances and others yet undiscovered probably will result in a further decrease in the use of open surgical procedures. The new, less invasive treatments are not without the possibility of complications, but in general they are more easily tolerated by the patient and can be done as an outpatient procedure or with a short hospital stay.

Our data shows many more procedures per year between 1987–1989 (302) as opposed to 1982–1984 (125). This is due to two factors; one, the doubling of the number of urologists practicing in the group from five to ten, and two, to more patients consenting to stone treatment with the introduction of less invasive techniques.

In spite of less invasive approaches to surgical stone management, prevention must not be forgotten. More stones are available for analysis now that more patients are consenting to these less invasive procedures. The physician should use this information to help in identifying possible causes of the patient's stone formation. Such information may allow therapeutic intervention to prevent or decrease the incidence of recurrent calculi.

This data is indicative of how quickly the practice of medicine can evolve and how it behooves all practicing physicians to be amenable to change and constantly aware of new developments in their field. Only in this way can the patient be offered optimal care.

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Consultation Patterns in an Urban Hospital Setting

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Physicians request consultations for a complex variety of professional, personal, and financial reasons.[1,2] Cases differ in their complexity and physicians differ in their ability to tolerate uncertainty regarding diagnoses and treatment. Patient expectations, hospital guidelines, and fear of litigation may pressure a physician to obtain a consultation. Physicians practicing in rural community settings may request fewer consultations than those practicing in urban academic medical centers. Family practioners may request fewer consultations than internists.[3]

Consultants frequently offer multiple recommendations regarding patient care. Sears and Charlson, in their study of 202 general medical consultations in a hospital setting, reported an average of 6.2 treatment recommendations per patient consult.[4] In a review of 156 consultations in a teaching hospital, Lee and his colleagues found that over 90% of consultations contributed significantly to patient care.[5] Only 2% were judged to be purely of educational value. In addition to improving patient care, consultations contribute significantly to continuing medical education and intellectual stimulation in both teaching and community hospitals.

In some instances specialty consultations impact directly upon physician salaries. Health maintenance organizations often provide negative financial incentives to primary care physicians to encourage them to limit their use of specialists. Should Congress adopt a prospective payment plan for physician services, primary care physicians and consulting specialists will share a predetermined sum for the treatment of medicare patients during a given hospitalization.[1]

The purpose of this study was to examine inhospital consultation patterns on a general internal medicine teaching service.

From the Department of General Internal Medicine (Drs. Bienia and Heuser) and the Office of Educational Affairs (Baroline Bienia), Eastern Virginia Medical School. Dr. Bienia is now a medical attache with the United States Department of State and the Foreign Service and should be addressed at the American Embassy, APO New York 09155.

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Method

Norfolk General Hospital is a 644-bed, high-technology hospital and a major teaching institution of the Eastern Virginia Medical School. The teaching service provides medical care to a primarily urban, inner-city population. None of the general medical attendings have subspecialty training. Patients generally are admitted through the emergency room, with a smaller number admitted via the hospital's ambulatory care clinics. Patients often are critically ill at the time of hospital admission and usually are not known to either the general medical attending physician or the medical residents providing their care.

During the period of this study, 112 consecutive admissions on alternate months to the general medicine teaching service were evaluated. A record was kept of the patient's admission diagnosis, the number and type of specialty consultations obtained and the reason for each consultation. The data were tabulated and the consultation patterns examined.

Results

The average age of the 112 patients included in this study was 53 years (range 20 to 109 years); 47% were male and 85% were black; and 32% required admission to an intensive care unit, which is consistent with previous reports that teaching hospitals treat a high percentage of seriously ill patients.[6]

Table 1 lists the frequency of admission diagnoses by specialty area. Patients with cardiac problems were the most frequently admitted, followed by patients with gastroenterologic, neurologic, and pulmonary diseases. Specific disease patterns vary among institutions and with the time of the year. With the exception of fewer oncology cases, the disease distribution found in this study generally is consistent with data reported by previous investigators.[7,8]

Table 1. Admission Diagnosis by Specialty Area (Number of Patients = 112).

Cardiology	32%	Hematology/Oncology	5%
Gastroenterology	19%	Nephrology	5%
Neurology	13%	Endocrinology	5%
Pulmonary Medicine	11%	Infectious Disease	4%
Other	4%		

Specialty consultations were requested on 64% (72) of the 112 patients included in this study. Eighty-three percent of patients whose hospitalization required an intensive care unit admission received consultations, compared to 55% for those who did not require that level of care. Twenty-one percent (24) of the patients required multiple consultations during the period of their hospitalization.

Table 2 lists the frequency of consultations by specialty area. A total of 124 consultations were obtained on the 112 patients for an average rate of 1.1 consultations per patient. The majority of consultations (52%) were obtained from medical specialties.

General surgery and the surgical specialties accounted for 34% of the consultations, psychiatry for 12% and obstetrics/gynecology for 0.8%.

Table 2. Specialty Consultations Requested (n = 124).

General Surgery	13%	Gastroenterology	8%
Surgical Specialties	18%	Hematology/Oncology	7%
Psychiatry	12%	Infectious Disease	5%
Neurology	10%	Nephrology	3%
Cardiology	9%	Rheumatology	3%
Pulmonary Medicine	9%	Obstetrics/Gynecology	0.8%
Other	4%		

The data were examined to determine if the principal aim of the consultation was a technical procedure or a recommendation for patient management. On 24% (30) of the consultations, a technical procedure (gastroscopy, coronary angiography, etc.) was performed by the specialist. The significant contribution on the remaining 76% (94) of the consultations was a diagnostic impression or recommendation for patient management. No consultations were requested for educational purposes only.

Lastly, the data were examined to determine a theoretical consultation rate had the patients in this study been admitted to the specialty service indicated by their admission diagnosis service rather than to a general medicine service. A conservative assumption was made that specialists would require the same additional consultations outside their specialty area as did the general internists. Under these hypothetical conditions 42% (47) of the patients still would require one or more additional consultations, resulting in an average rate of 0.71 consultations per patient. This is lower than the average of 1.1 consultations per patient which occurred in the actual study.

Discussion

This study was conducted in a large urban hospital offering easy access to high technology medicine equipment and all major specialty consultants. At least one specialty consultation was requested on 64% of the study patients admitted to the general medical teaching service. Consultations were not obtained solely for educational purposes. This consultation rate reflects, therefore, the standard of care residents presently are being taught to emulate in their subsequent medical careers.

No previous information has been published regarding the inhospital consultation rates of general internists. Weiss and Gardner reported an average of 0.47 consultations per patient on the family medicine service at the University Medical Center in Tucson, Arizona.[3] Luke and Thomson reported 0.89 and 0.61 consultations per patient on two private, multispecialty group practices in Denver, Colorado.[9] On 24% of the consultations in our study a technical procedure beyond a general internist's capabilities was performed. Therefore, 24% would represent the minimum theoretical consultation rate in this study population.

The majority of consultations (52%) in this study were requested from medical specialists. This was expected, since the emergency room triage process selectively admits patients with primarily medical problems to the internal medicine service. Consultations were not requested proportionally from all specialty areas. Of patients admitted with a cardiological diagnosis, 31% received a cardiology consultation. All of the patients admitted with a cancer diagnosis received an oncology consultation. This suggests that general internists may be better trained or more comfortable in managing certain disease categories than others.

The principle contribution of 76% of the consultations in this study was a diagnostic impression or recommendation on patient management, not a technical procedure. Lowering this consultation rate presents a major challenge for medical educators. Alternative approaches to the training of primary care physicians have been suggested. Schroeder and his colleagues have advocated shifting some internal medicine training from inhospital to ambulatory settings and placing more emphasis on surgical and nonmedical content areas.[10] These changes might reduce consultations to the nonmedical specialties but it is unlikely they would change consultation rates for the medical specialties.

Internal medicine residency programs are intense educational experiences. It may no longer be possible to obtain in three years the breadth of medical knowledge needed in ambulatory medicine as well as the depth of knowledge required for hospital medicine. Without this knowledge, general internists may risk becoming little more than routing clerks for hospitalized patients.[1]

An alternative approach would be to hospitalize patients directly under a medical specialist's care and return them to the primary care physician's supervision after discharge. Aiken and colleagues have noted that specialists already provide significant primary care services.[11] Our study points out, however, that this approach still would require multiple additional consultations on hospitalized patients.

Conclusions

Hospital medicine is technically complex. Increasingly, patients are managed by teams of physicians representing multiple specialties. Sixty-four percent of the patients in this study required at least one consultation during their hospitalization. The consultation rate probably would be lower in an outpatient setting or if the patients had prior ongoing medical relationships with the general internists involved in their care.

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SAFE DRIVERS

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ABSTRACTS

These are the three prize winning abstracts presented on Kinloch Nelson Medical Student Honors Day at the Medical College of Virginia/Virginia Commonwealth University on May 10, 1989. Faculty advisers are listed as coauthors.

Enhanced Superoxide Anion Generation by Porcine Neutrophils Following In Vitro and In Vivo Exposure to Live *Pseudomonas aeruginosa*. A.M. Schneider (M-91), K. Byrne, MD, P.D. Carey, MD, C.R. Blocher, BS, A.A. Fowler, MD, and H.J. Sugerman, MD.

Generation of superoxide anion (O_2^-) by activated neutrophils has been implicated in the pathogenesis of endothelial cell injury during acute sepsis. To quantitate this phenomenon, we studied the kinetics of O_2^- production (cytochrome C reduction at 550nm, phorbol myristate acetate stimulation) by *Pseudomonas*-primed neutrophils in an in-vitro system (1×10^6 porcine neutrophils/ml incubated in stirred cuvettes with live *Pseudomonas* for 1hr at 37°C) and in vivo (neutrophils isolated from young swine before and after a 1hr infusion with 5×10^8organisms/ml at 0.3 ml/20kg/min) compared to in vitro and in vivo saline controls. Neutrophils from septic pigs exhibited a significantly increased ($p < 0.05$) initial burst of O_2^- production compared with controls (Figure 1). Neutrophils exposed to bacteria in vitro displayed a similarly enhanced rate of O_2^- production (Figure 2).

Figure 1

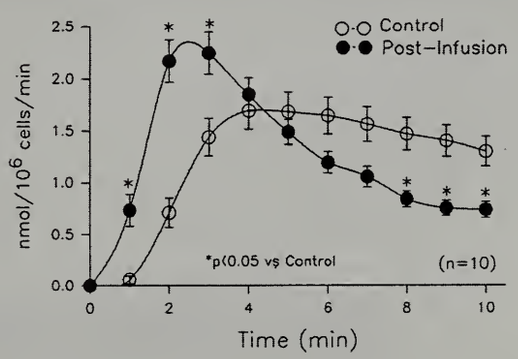
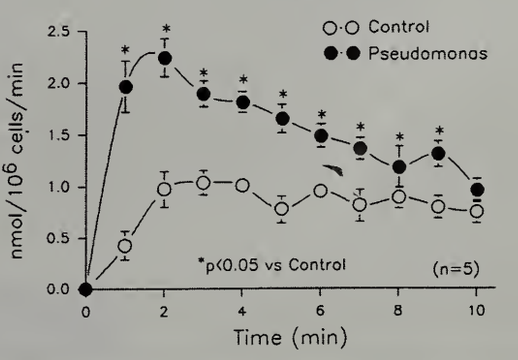


Figure 2



These results demonstrate that priming of porcine neutrophils with live bacteria, both in vitro and in vivo, leads to a markedly increased initial rate of O_2^- production. This burst of O_2^- activity may overwhelm endogenous antioxidant mechanisms and contribute to the increased permeability from endothelial cell injury seen in sepsis.

Cytochemical Demonstration of Superoxide in Cerebral Inflammation and Ischemia/Reperfusion. Christopher D. Kontos (M-89), John T. Povlishock, PhD, and Enoch P. Wei, MD.

Recent research has implicated free radicals as mediators of tissue destruction in a number of pathologic processes, including inflammation and ischemia/reperfusion injury. Although it is accepted that the source of damaging oxygen free radicals in inflammation is the plasma membrane-based NADPH oxidase system, the precise mechanism of radical production in other processes has yet to be elucidated. The ultrastructural localization of the source of damaging oxygen metabolites was first accomplished by Briggs et al (Histochem 1986;84:371) in the case of inflammation through the utilization of a cytochemical technique to demonstrate the production of superoxide (O_2^-) in vitro by monolayers of polymorphonuclear leukocytes (PMNs). In this report, we adapt the technique of Briggs et al. to an in vivo situation using chemical meningitis induced in cats by the topical application of the mucopolysaccharide carrageenan beneath cranial windows. Chemotactically attracted leukocytes were then maximally stimulated with phorbol myristate acetate and exposed to Mn^{2+}, diaminobenzidine (DAB), and sodium azide (to inhibit endogenous peroxidatic activity). Superoxide oxidizes Mn^{2+} to Mn^{3+}, which then oxidizes DAB to form an electron dense reaction product (EDRP) when reacted with osmium tetroxide. The tissue was then processed for routine transmission electron microscopy. This approach yielded an EDRP identical to that described by Briggs et al, which was localized at the external plasma membrane and on the luminal surface of the phagocytic vacuoles of the PMNs. The reaction product was stable, well localized to membranes, and it was inhibited by the addition of superoxide dismutase (SOD) to the medium, implicating NADPH oxidase-generated O_2^- as the source of reaction product.

Having demonstrated the applicability of the DAB/Mn^{2+} technique in vivo, the second phase of this experiment involved its application to ischemia/reperfusion injury, where the source of free radicals is less well defined. Here the EDRP was diffusely distributed throughout the subarachnoid space, it was inhibited by SOD, and although the reaction product was not localized to a precise cellular or subcellular structure, both vascular endothelium and smooth muscle appear likely candidates. These results demonstrate the usefulness of this cytochemical technique in vivo and suggest its utility in the study of O_2^- in other organ systems.

Fibrin Coating of Bladder Tumor Cells (T24) Not Protective Against LAK Cell Cytotoxicity. Anne Spaulding (M-89), Marcus E. Carr, Jr., MD, and Susan A. Sajer, MD.

Tumor cells in the circulation are enshrouded with a coat of fibrin. It has been suggested that this fibrin coat protects tumor cells from attack by the immune system. This study compared the interaction of lymphokine activated killer (LAK) cells with tumor cells alone, and with tumor cells coated with fibrin. LAK cell killing of cultured human bladder tumor cells (T24) was measured by a 4 hr chromium release assay. Tumor cells 3×10^6 were incubated with $Na^{51}CrO_4$ for 2 hrs at 37°C, 5% CO_2 in serum free medium. After washing, one-half of the cells were coated with fibrin by exposure to recalcified platelet poor plasma. Fibrin coating was confirmed by immunofluorescence with antihuman fibrinogen fluorescein conjugated antibodies. LAK cells were prepared from peripheral blood lymphocytes (PBL) by incubation with interlukin 2 (IL2) at a concentration of 1000u IL2/1mL SFM/1 million cells for 5 days at 37°C, 5% CO_2. 5000 tumor cells with or without fibrin were incubated with varying concentrations of either LAK or PBL (10,000 to 100,000 cells). After 4 hrs the supernatant was harvested and counted in a gamma counter for 1 min. At a ratio of 100:1 (LAK to T24), the % specific lysis was 83.4% with T24 alone and 76.6% with T24 with fibrin. This suggests that fibrin coating of tumor cells does not provide protection from LAK cell killing. The role of other killer cells, including NK cells and cytotoxic T lymphocytes, remains to be determined.

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EDITORIAL

Medical Students

THE admissions officer of a prominent United States medical school recently was commenting on the drop in medical school applications in this country. He cited three major reasons for this decline in interest, but the one most frequently voiced by prospective students was lack of encouragement by physicians themselves.

It is presumed that the prospective students were referring to older physicians. If so, they were right on target. Those physicians who have been in practice for less than ten years (a cutoff time used loosely) have known only the present system, and the movement toward control by government and big business has been well established. In the main these physicians are not happy with the situation, but they are able to adjust. To a lesser degree this is also true for the academicians, whose professional life is more structured.

For the older physicians, those who have been in private practice for more than ten years, the present climate for the practice of medicine is barely tolerable. Some are modifying the way they practice: An example is the obstetrician-gynecologist who no longer delivers babies. Others are leaving private practice to accept salaried positions in hospitals, clinics or HMOs, or to enter academia. Some continue as before, but many of those who can adjust their professional lives, are doing so.

While it might be expected that older physicians would be unenthusiastic about the changes in the practice of medicine, it must be remembered that the United States presently is blessed with the most advanced medicine in the history of the world. That fact alone ought to be ample incentive for one considering medicine as a profession. But don't ask the older physician.

E.L.K., JR.

Don't Bite the Hand That Feeds You

A SAD event happened a few days ago to a friend of mine. He was backing his car out of his driveway on his way to a golf game when he heard a scream. After quickly changing directions he got out to find that he had backed over his much-loved dog. Brandy is a long-haired dachshund and the apple of Don's eye. Her hind legs were mangled, but she was alive. When Don rushed to comfort her, she bit his hand and refused to let go. It took much effort to release her teeth, wrap her in a blanket, and get her to a vet. Two operations to repair one broken leg, one torn Achilles tendon, and extensive skin avulsions have been performed, and everyone is hopeful about the outcome. Don's hand is getting better, but his golf game is still on hold after two weeks.

The fact that this injured dog attacked the one who loved her most and was most able to help her can be attributed to fear. I was intrigued by this vignette when I thought about the way physicians attack and refuse to support their own colleagues and organizations in the face of so many outside threats and negative forces. I suspect that fear of the unknown and pain

cause the same reaction regardless of species. Relating this story to those who read this journal is like preaching to the choir. I know I am not reaching those physicians who refuse to support our organizations because of single issues or unintended painful acts, but the parallel is inescapable. Brandy has returned her affection to Don, but where are the nonsupporting physicians of Virginia?

LEON I. BLOCK, MD

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Wiser?

In the middle of August I realized that my garden was at its peak and that I was a little beyond my peak. Being tired lasted longer, climbing hills was harder, and rushing about was now a misnomer.

But aging has its compensations. As I get older and as my remaining fringe of hair gets grayer, I get far more respect than when I was just bald. Although by nature a very modest person, I readily allow people to assume that my increased age is accompanied by increased wisdom. Younger people expect an older person to have had more experience than they and therefore to be able to give them wise counsel.

So now they come and ask me for advice, the same as I once asked my wiser elders. I give them an answer as best I can. But I am certain that I do not know as much nor am I nearly as wise and experienced and reliable as those seeking my advice think and hope.

I have a horrifying thought: Maybe those older and wiser people who counseled me were beset by the same doubts.

H. S. CAMPELL, MD

Making a Decision

Every ophthalmologist knows how hard it is for most patients to make a decision about cataract surgery. You sit and explain the problem and the options. There is not a right or wrong decision, and the patient needs to decide if the visual disability justifies the surgery.

Perhaps the patient and the relatives will ask a few questions. You answer them and then ask the patient if he or she would like to decide now or think it over for a few days. Usually the patients will tell me that they are ready and willing to do whatever I advise. They seem to have missed my point: They need to decide on their degree of disability.

Deciding on your degree of disability from a physical infirmity is not always easy because you cannot readily compare yourself to someone without that problem and you cannot quite remember how it was before the problem.

A few years ago I had progressive symptoms of prostatism without my being able to decide if my problem was bad enough to warrant surgery. So it took me longer to urinate than it used to. So I had to wake up two times at night. I thought that I was doing reasonably well and was willing to tolerate my symptoms for a while longer.

My wife and I were driving along the interstate highway. My two hours were up when we got to a rest stop. Traffic was light that morning, and we were the only car in the parking area when I went into the building.

As I began to urinate, a very old, frail and feeble man entered. He was breathing hard and fumbling with the zipper on his fly. A horrible thought entered my mind. This poor old man has bladder outlet obstruction and is desperate. He has a urologic emergency. What can I do out here in the middle of nowhere with absolutely no medical equipment. Where was the closest hospital and/or urologist. What on earth would I do if he collapsed. I was worried.

He urinated, washed and dried his hands, and left long before I finished. I knew that I was ready.

H. S. CAMPELL, MD

The Medical Society of Virginia's 142nd Annual Meeting at the Richmond Marriott November 8-12, 1989

SPECIALTY MEETINGS

These specialty societies have scheduled adjunct breakfast or luncheon sessions:

American Association of Public Health Physicians
American College of Physicians, Virginia Chapter
Psychiatric Society of Virginia
Virginia Allergy Society
Virginia Obstetrical/Gynecological Society
Virginia Orthopaedic Society
Virginia Chapter, American College of Radiology
Virginia Dermatological Society
Virginia Pediatric Society
Virginia Society of Anesthesiologists
Virginia Society of Internal Medicine
Virginia Society of Ophthalmology
Virginia Society of Otolaryngology
Virginia Society for Pathology
Virginia Society of Physical Medicine/Rehabilitation
Virginia Urological Society

DETAILS OF THESE AND OTHER EVENTS IN VA MED'S OCTOBER ISSUE

PRELIMINARY PROGRAM

Friday, November 10

Who Will Meet Tomorrow's Nursing Needs?: Anne MacCallum, RN, Patricia Cushnie, William W. Regan, MD, and the Hon. Mary Marshall.

Geriatric Psychopharmacology: Pearson Sunderland III, MD, National Institutes of Health.

Pain Management: John Rowlingson, MD, Mark Lehman, PhD, and Gerald Goldstein, MD.

Ethical and Legal Aspects of Decisions to Forego Life-Sustaining Treatment in Virginia: John C. Fletcher, PhD, and Elizabeth S. Scott, JD.

Saturday, November 11

Lingamfelter Lecture in Dermatology: James E. Rasmussen, MD, University of Michigan School of Medicine.

Ophthalmology for the Non-Ophthalmologist: Robert C. Allen, MD, and Joseph J. Timmes, Jr., MD, Georgetown University School of Medicine.

Gallstone Lithotripsy Update: James Lind, MD.

Hotel Reservation

Annual Meeting of the Medical Society of Virginia, November 8-12, 1989,
at the Richmond Marriott, 500 East Broad Street, Richmond VA 23219, (804) 643-3400
Rates: Double, $92, Single $82 plus 9.5% sales tax
Reservations must be received by October 18.

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OBITUARY

● **Gordon Gilbert Birdsong, MD,** obstetrician/gynecologist in Franklin for 32 years; University of Tennessee Center for the Health Sciences, 1939; age 75; died July 6, 1989.

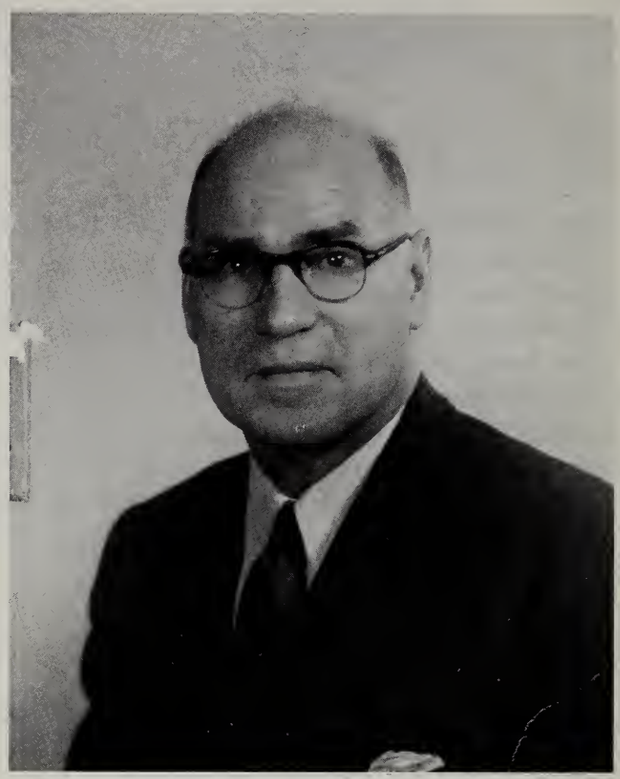
Memoir of Herman Braxton 1906–1988

By Randall H. Suslick, MD, and Earle W. Moore, MD

On November 18, 1988, Chase City and Southside Virginia lost an excellent physician, a friend, and an institution. On that evening, Dr. Herman Harrison Braxton passed away from a cardiac arrest minutes after returning home from a house call. He had just sat down in his favorite easy chair and was starting to read. Thus ended a long and eventful medical career that spanned 54 years.

Dr. Braxton was born November 13, 1906, in Alamance County, North Carolina. He received his undergraduate degree from the University of North Carolina, his MD degree from Johns Hopkins University, and did his internship at Duke University Hospital and one year of residency in White Plains, New York. He began his practice in Chase City in 1934. His medical career was varied and exciting. Stories of his medical adventures during the days of many home visits over unpaved roads have taken on a legendary flavor. He rode horseback for ten miles through the two-foot snowfall of 1940 to deliver a baby, a time when even the trains could not run and roads were impassable. He almost fit the archetype of "old-fashioned country doctor," but he was much more. He was ever seeking more knowledge and skill, and rejoiced in the fantastic expansion of medical knowledge available to doctors as the years went by.

Dr. Braxton was very civic minded. He served on the Chase City Town Council, was a former president of the Chase City Chamber of Commerce, a former member of the Central Fidelity Bank Advisory Board, a former board member of the Chase City Industrial Development, Inc., and a charter member of the Chase City Lion's Club. He was a vestryman and trustee in St. John's Episcopal Church in Chase City. Dr. Braxton received many honors. Among these honors were the Chase City Jaycees' Outstanding Citizen Award in 1968, the Sertoma Club's Service to Mankind Award in 1975, and the Chase City Chamber of Commerce's Citizen of the Year Award in 1985. It is



HERMAN H. BRAXTON, MD
1906-1988

because of Dr. Braxton's community leadership and ability at recruitment that Chase City today has a modern medical clinic staffed with two young physicians. He has been listed in *Who's Who in the South and Southwest.*

Dr. Braxton was a fellow and charter member of the American Academy of Family Practice, a member of the Medical Society of Virginia, the Old Belt Medical Society, and the American Medical Association. He was one of the first medical examiners in the State of Virginia when the state office was established in 1948 and served in that capacity until his death.

Dr. Braxton had a favorite quotation that summed up his dedicated service in Chase City: "I hope my life is being measured certainly not on my number of servants but on how many I served."

Dr. Braxton's wife, Ann Grimm Braxton, survives him, as does his son, Herman Harrison Braxton, Jr., of Fredericksburg, Virginia; a daughter, Elizabeth Anne Braxton of Athens, Ohio; and three grandchildren.

The people of Chase City will miss Dr. Braxton. He left a legacy that few can hope to achieve.

Memoir of Ben Sheppard 1905–1989

By John B. H. Caldwell, MD, and Maynard P. Smith, MD

Dr. L. Benjamin Sheppard died on March 8, 1989, at age 83. He had practiced ophthalmology in Richmond for 50 years until his retirement in 1986, with time out for military service during World War II.

Born and reared in then rural Glen Allen, young Benjamin commuted to Richmond's John Marshall High School to complete his secondary education. The spirit of country living imbued his personality, and he retained and shared those values throughout his life. He cherished his background and his family and was appropriately proud of his deep Virginia roots.

Ben Sheppard furthered his education at the University of Virginia, attending college there and receiving his medical degree in 1930. He continued to keep up with many of his medical class, whose remaining members continue to meet annually in Charlottesville.

Medical training was continued at the Medical College of Virginia from 1930 to 1933, and at the Manhattan Eye, Ear and Throat Hospital in New York City 1933 to 1935. He also undertook a preceptorship with Dr. Conrad Berens in New York before returning to Richmond, where he would maintain an office in the Medical Arts Building until his retirement.

Ben Sheppard sustained an abiding interest in ophthalmic research and was the inspiration for considerable work in the anatomical and physiological aspects of eye disease. A special effort was in the area of congenital glaucoma, and for many years he had an association with the Jackson Laboratories in Bar Harbor, Maine, where a colony of buphthalmic rabbits was developed and made available for research.

The Richmond Eye and Ear Hospital was a priority for Dr. Sheppard from its founding throughout the rest of his life. He nurtured it, supported it, promoted it, and had great visions for it. He, along with others, saw to it that the hospital had strong leadership and that it would offer the newest in worthwhile equipment for the service of its patients. His enthusiasm for the practice of medicine and ophthalmology led to his interest and sense of responsibility in encouraging a series of medical students and young practitioners over the years, and he continued extensive correspondence with a number of those individuals. His interest in the history of medicine led, as one example, to extended research in the life and medical practice of one of America's pioneer doctors, John Peter Mettauer, of Prince Edward County. Dr. Sheppard was the Walter Reed Lecturer for the History Section of the Richmond Academy of Medicine in 1977.

Dr. Sheppard's professional life included participation on the staffs of several Richmond hospitals, appointments in the Departments of Anatomy and Ophthalmology at the Medical College of Virginia, board membership on the Richmond Eye and Ear Hospital, and membership in numerous medical organizations. He was a diplomate of the American Board of Ophthalmology and was elected to the elite American Ophthalmological Society. He was president of the Virginia Society of Ophthalmology and Otolaryngology in 1956.

Dr. Sheppard's community life was marked by his lifelong involvement with the church, Hunton Baptist Church of his youth, and Bethlehem Lutheran Church after his marriage. He had been active at the board level in the YMCA, and was a devoted and very active member of the Richmond Rotary Club, serving as its president in 1956.

Ben's personal life was enriched by his travels to many parts of the world, and he loved to tell the tales of his experiences. To the year of his death he continued to plan and tend his vegetable garden at his Riverside Drive home. At a summer home on the Potomac River, he loved to fish, to care for the cabin, and to generously share its amenities.

"Dr. Ben" was married to the former Helen Nolde, who died in 1953. His second wife, Elizabeth Groves Sheppard, survives.

Ben Sheppard was a warm and faithful friend to many, regularly visiting, calling, and writing; his goodness and ebullient good humor endeared him to friends and patients alike; his tenacity in the pursuit of goals marked him as a man of zeal and determination; his straightforward faith allowed him to face death with confidence and serenity.

News of the death of a Medical Society of Virginia member may appear in these pages in either or both of two ways: 1) a brief notice written by staff giving factual information; 2) a memoir contributed by a physician who knew the deceased peer and writes a personal account of his or her life. If the memoir is contributed before the brief notice is inserted, it is published at once; if after, it is set in type to be published as space permits.

How to Report AIDS and HIV Infection in Virginia

Who should report? Every Virginia physician is required by law to report any case or suspected case of AIDS under his or her care, and as of July 1, 1989, the reporting of HIV infection became mandatory also. Reports are kept confidential, as the law specifies.

What should be reported? The presence of a reliably diagnosed disease at least moderately indicative of an underlying cellular immune deficiency, with no other known underlying cause of cellular immune deficiency nor any other cause of reduced resistance associated with that disease, should be reported as AIDS.

Only patients who have positive blood test for HIV antibodies as demonstrated by at least two enzyme-linked immunosorbent assays (done in duplicate at the same time or singly at different times) and another testing procedure, such as the Western blot, should be reported as having HIV infection.

When should I report? As soon as possible after you first provide care for the patient.

Where should I report? To the local health department serving the jurisdiction in which your practice is located.

Prepared for VIRGINIA MEDICAL by the Virginia Department of Health

NEW MSV MEMBERS

Albemarle County Medical Society

Patricia W. Smith, MD, Ophthalmology, Box 475, University of Virginia Health Sciences Center, Charlottesville VA 22908

Alexandria Medical Society

Maria R. Alivisatos, MD, Infectious Diseases, 2817 Duke Street, Alexandria VA 22314

Elaine R. Green, MD, Psychiatry, 303 Kentucky Avenue, Alexandria VA 22305

Roberta Kalafut, DO, Psychiatry, 5201 Leesburg Pike, Falls Church VA 22041

Arlington County Medical Society

Kathleen N. Price, MD, Rheumatology, 2101 Grayson Place, Falls Church VA 22043

Warren S. Levy, MD, Cardiology, 1715 North George Mason Drive, Arlington VA 22205

Chesapeake Medical Society

N. Fatehi, MD, Neurological Surgery, 1020 Independence Boulevard, Virginia Beach VA 23455

Fairfax County Medical Society

Bechara F. Akl, MD, Cardiac/Thoracic Surgery, 3301 Woodburn Road, Annandale VA 22003

Nelson A. Burton, MD, Cardiac/Thoracic Surgery, 3301 Woodburn Road, Annandale VA 22003

Paul E. DiLorenzo, MD, Cardiovascular Diseases, 8601 Farrell Court, Chevy Chase MD 20815

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Tahira Habib, MD, Endocrinology, 2616 Sherwood Hall Lane, Alexandria VA 22306

Stuart E. Katz, MD, Urology, 309 Yoakum Parkway, Alexandria VA 22304

Robert C. Mackow, MD, Nephrology, 3650 Joseph Siewick Drive, Fairfax VA 22033

Linda S. Sigmund, MD, Neurology, 3020 Hamaker Court, Fairfax VA 22031

Fauquier County Medical Society

L. Trice Gravatte IV, MD, Family Practice, 919 Highland Court, Warrenton VA 22186

Halifax County Medical Society

Mark A. Benson, MD, Urology, 640 Cavalier Boulevard, South Boston VA 24592

Lynchburg Academy of Medicine

Robert L. Green, MD, Diagnostic Radiology, 2007 Tate Springs Road, Lynchburg VA 24501

Michael R. Paling, MD, Radiology, 2007 Tate Springs Road, Lynchburg VA 24501

J. Scott Wade, MD, Internal Medicine/Infectious Diseases, 2215 Landover Place, Lynchburg VA 24501

Newport News Medical Society

John C. Maddox, MD, Pathology, 131 James Landing Road, Newport News VA 23606

Richard P. Moriarty, MD, Pathology, 2824 Meadow Green Court, Chesapeake VA 23321

Norfolk Academy of Medicine

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Paul J. Bohdiewicz, MD, Diagnostic Radiology, 6161 Kempsville Circle, Norfolk VA 23502

Craig B. Froede, MD, Internal Medicine, 6161 Kempsville Circle, Norfolk VA 23502

Northern Virginia Medical Society

Stuart A. Monroe, MD, Pathology, Winchester Medical Center, Winchester VA 22601

Paul J. Ulich, MD, General Surgery, 20 South Stewart Street, Winchester VA 22601

Patrick Henry Medical Society

Ronald M. Blum, MD, Pulmonary Diseases, 312 Fairy Street, Martinsville VA 24112

Portsmouth Academy of Medicine

Kasedul Hoq, MD, Family Practice, 3116-A Tyreneck Road, Portsmouth VA 23703

Prince William County Medical Society

Susan J. Shlifer, MD, Family Practice, 10633 Crestwood Drive, Manassas VA 22110

Richmond Academy of Medicine

Judith A. Fabian, MD, Anesthesiology, 4322 Monument Park, Richmond VA 23230

Duncan C. MacIvor, MD, Obstetrics/Gynecology, 1753 Jahnke Road, Richmond VA 23225

M. Paul Millet, MD, Neurology, 9510 Heather Spring Drive, Richmond VA 23233

Harry B. Peppiatt, MD, Nephrology, 1011-C Hioaks Road, Richmond VA 23225

David C. Reutinger, MD, Obstetrics/Gynecology, 7151 Jahnke Road, Richmond VA 23235

J. Peter Van Dorsten, MD, Obstetrics/Gynecology, Box 34, MCV Station, Richmond VA 23298

James W. Woolridge, Jr., MD, Child/Adolescent/Adult Psychiatry, 1500 Westbrook Avenue, Richmond VA 23227

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Robert M. Seamon, MD, Internal Medicine, 1603 Franklin Road SW, Roanoke VA 24016

Rockingham County Medical Society

Charles E. Kern, MD, Anesthesiology, 1840 East Market Street, Harrisonburg VA 22801

Smyth County Medical Society

Jaime Polit, MD, Internal Medicine, 502 East Main Street, Marion VA 24354

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Manuscript Preparation

Medical articles, editorials, essays, Letters to the Editor and all other text submitted for publication must be double-spaced throughout, including references, legends and all other elements. The material should be typed on one side of the paper, with generous margins of at least 1¼ inches all around. Do not use all-caps or a script typeface. Submit one original of the communication and one copy. If the material is not accepted, the original will be returned; the copy will be retained.

The author is responsible for the accuracy of all statements and references. Acronyms and other abbreviations should be kept to a minimum; unless an acronym is widely known and used by all specialties, it should be fully explained in the text. Refer to pharmaceutical products by their generic names; brand names may follow in parentheses and should carry registered trademarks where applicable. All units of measure should appear in the metric system. References, typed in double-space, should be listed in the order of their citation in the text, not alphabetically. They should follow Virginia Medical's typographic style for references; the typist should study this style as it appears in each issue.

Illustrations should be black and white glossy prints, with legends typed in double-space on a separate sheet of paper. Virginia Medical has no budget for printing in color; the author who wishes to publish a four-color figure may negotiate to pay for the costs.

Attach to the contribution a covering letter giving the address and telephone number of the person who will correspond about it and address the completed communication to the Editors, Virginia Medical, 4205 Dover Road, Richmond VA 23221.

All manuscripts are subject to editorial changes. If extensive revision is deemed necessary, the author will receive for approval a draft of the article as edited.

There are many excellent handbooks of effective writing, among them *The Elements of Style,* by William Strunk, Jr., and E. B. White (MacMillan); *The Careful Writer: A Modern Guide to English Usage,* by Theodore M. Bernstein (Atheneum); and *How to Write and Publish a Scientific Paper,* by Robert A. Day (ISI Press).

Beware of Buzzwords:

They mininform, insult, and promote ignorance.

These buzzwords were assembled by the AIDS Coalition to Unleash Power (ACT UP). The first seven comments, in quotes, were made by Jody Powell, former White House press secretary, and appeared in *You Can Do Something About AIDS*, published by The Stop AIDS Project, Boston, Massachusetts, 1988.

Term	Problem
Bodily fluids	". . . should never be used without an explanation of which bodily fluids actually contain the HIV virus in concentrations sufficient to transmit the disease . . . Sweat, saliva, and tears are all bodily fluids, but do not carry a threat of HIV infection. Reports on AIDS should make it clear that semen, vaginal fluids, and blood are the concern here."
General population	". . . artificially divides the American people into those who have the disease and those who do not. Everyone who has AIDS—regardless of sexual orientation, race, gender, or how they were exposed to the virus—is part of the 'general population.' "
High risk groups	". . . implies that some kind of demographic trait, rather than behavioral practice, is responsible for AIDS exposure." *Appropriate Term:* High risk behavior
AIDS victims	"People with AIDS are not victims; they are people struggling to live normal lives in the face of a fatal disease. We don't refer to people with other diseases as victims . . ." *Most Preferable Phrase:* People with AIDS
HIV virus vs AIDS	"Many people still confuse exposure to the HIV virus with the disease itself. More than one million people are believed to have been exposed to the virus; some 50,000 actual cases have been reported."* Always explain the difference.
Condoms	"Reports recommending condom use to reduce the risk of HIV exposure should clearly state that latex condoms with a spermacide are preferable (natural lamb condoms may not provide the necessary protection.)"
Intimate sexual contact	". . . a polite phrase that doesn't tell the reader anything useful (many people regard kissing and fondling as intimate). Certain sexual practices—especially unprotected anal intercourse—are known to pose a much greater chance of HIV transmission than others. Articles should make this clear."
Innocent victims	A term sometimes applied to children with AIDS or those who contracted AIDS through blood transfusions; a value judgment that implies that some people with AIDS may be guilty of something. "Victims" is also a problem (see above).
AIDS carrier	The term "carrier" is reminiscent of the typhoid hysteria of the 1920s and can incite similar reactions. *Appropriate Terms:* HIV (antibody) positive person or person with AIDS, depending on condition.
AIDS activism vs gay rights	AIDS activist groups are sometimes incorrectly called gay rights groups. While some AIDS activists also campaign for gay rights, and some issues may overlap, the two subjects should not be confused.
Having sex	Vague; see "Intimate sexual contact" above.

*Outdated figures

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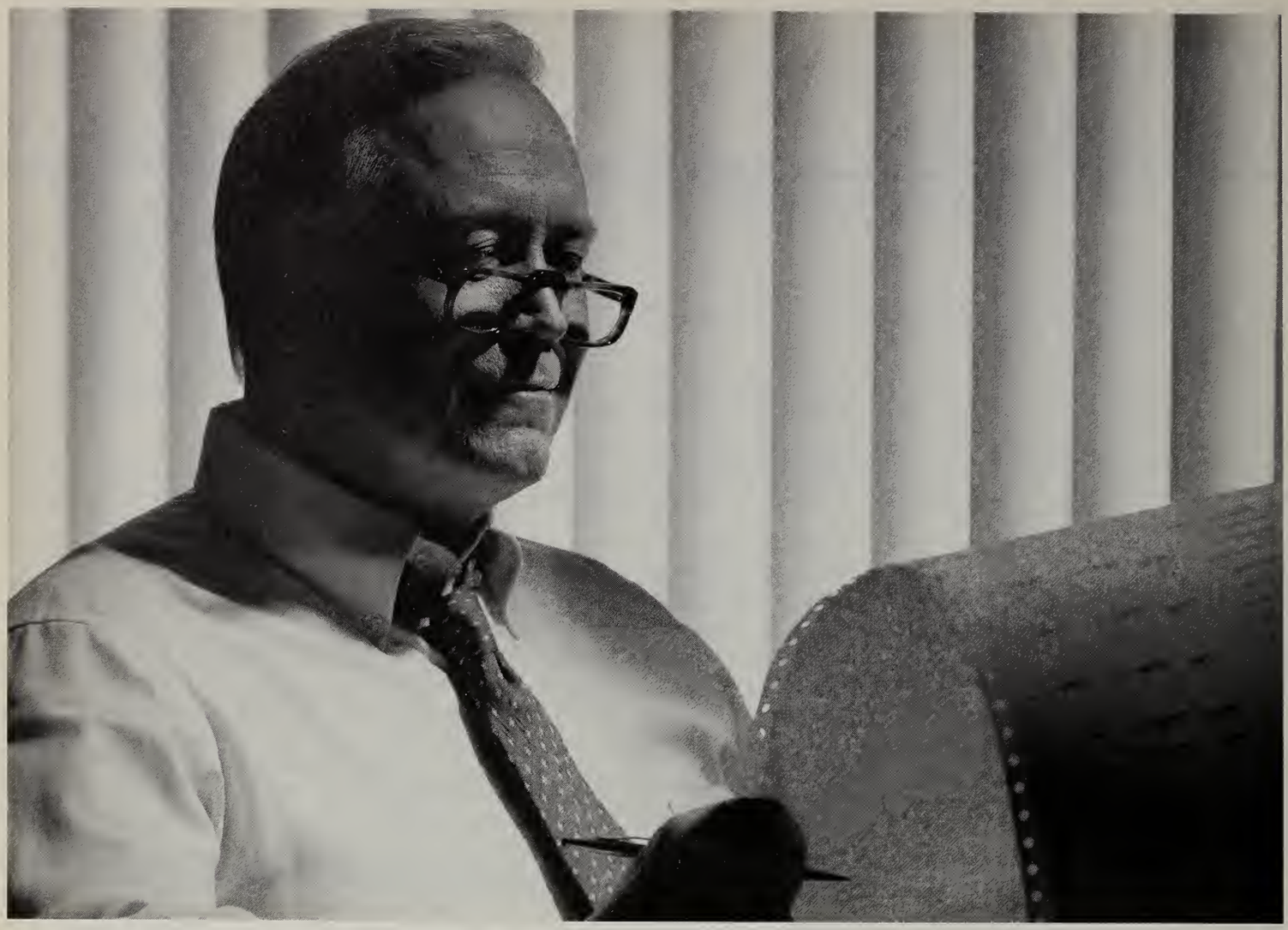

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Consent Forms for Virginia's New AIDS Law

Effective the first day of this month, Virginia law requires that informed consent be obtained before any HIV testing is performed. This requirement joins the "deemed consent" provision that became effective July 1, 1989. To implement both elements of this legislation, the Medical Society of Virginia and the Virginia Hospital Association have cooperated in the development of sample consent forms and guidelines for adapting them to use by physicians in their offices and by hospitals.

The guidelines and consent forms in these pages were developed by Sandra L. Kramer, general counsel, the Medical Society of Virginia, and Katharine M. Webb, vice president for government relations, the Virginia Hospital Association. They were assisted by risk managers from the Virginia Insurance Reciprocal.

It should be noted that the guidelines and consent forms are presented here as useful information. They are not intended, and should not be used, as a substitute for consultation with legal counsel.

All of the material in this section has been broadsided to the chief executive officers, medical staff chiefs, and infection control directors of the member institutions of the Virgina Hospital Association.

Physicians who have questions about the law or its implementation may call Jonathan Perry at Medical Society of Virginia headquarters in Richmond, 804-353-2721.

Guidelines for Obtaining Consent

Elements of the Consent Form

The following elements should be included in a consent form for HIV testing:

a. The full name of the person to be tested.
b. The date upon which consent is sought.
c. The purpose of HIV testing, i.e., to detect HIV antibodies, and a statement indicating the relationship between HIV infection and AIDS.
d. An explanation of the nature of the testing, i.e., the need to perform confirmatory tests.
e. An explanation of the limitations of the testing, i.e., that it does not offer sufficient information alone upon which to diagnose AIDS, and the possibilty of false positive and false negative results.
f. A statement notifying the subject of the testing that state law requires that all HIV positive results be reported to the local health department.
g. A statement indicating that the subject of the testing has been advised of the risks of drawing blood.
h. A statement indicating who will explain the test results to the subject of the testing.
i. A signature blank indicating that the subject of the testing, or his legally authorized representative, consents to HIV blood testing.

Documenting Refusal to Consent

In situations where patients refuse to consent to testing for HIV, it is recommended that this refusal be carefully documented in the medical record.

Disclosure/Counseling Requirements

Note that Virginia law requires that every person who is given a test for HIV antibodies (whether the test result is positive or negative) must be given an opportunity for face-to-face disclosure of the test results and appropriate counseling. Obtaining a consent to perform the test does not satisfy these requirements. Instead, verification that the disclosure and counseling requirements have been met should be documented separately in the medical record.

Guidelines for Notice of Deemed Consent

Definition and Implementation

Virginia law includes a "deemed consent" provision which requires that health care providers notify their patients that they will be "deemed" to have consented to human immunodeficiency virus (HIV) antibody testing and to the release of test results to health care providers when, according to then current Centers for Disease Control guidelines, the health care worker may have been exposed to the body fluids of the patient in a manner which may

Sample Form

CONSENT TO TEST FOR ANTIBODIES TO HIV VIRUS*
(Name of Physician's Practice)

Name:_____

Responsible Physician:_____

Date:_____ Time:_____ AM/PM

I understand that the purpose of HIV blood testing is to detect the presence of antibodies to the Human Immunodeficiency Virus (HIV), the virus that causes Acquired Immunodeficiency Syndrome (AIDS), and related disorders.

I understand that this is not a direct test for the virus, but a test for antibodies to the virus. The sample of blood is tested in two ways to confirm a positive test. I further understand that a positive blood test result does not mean that I have AIDS and that in order to diagnose AIDS, other means must be used in conjunction with the blood test.

I have been informed that the HIV blood test results may, in some cases, indicate that a person has antibodies to the virus when the person does not (false positive) or fail to detect that a person has antibodies to the virus when the person has antibodies (false negative). The possibility if a false positive result is minimized by performing other antibody tests when the first test is positive.

I understand that state law requires physicians to report to the local health department the identity of any patient who has tested positive for exposure to HIV.

I have been advised of the procedure for taking blood and the possible risks and consequences of such a procedure.

I understand that the results of my HIV testing will be explained to me by my physician.

By my signature below, I acknowledge that I have been given all of the information I desire concerning the HIV antibody blood testing and all of my questions have been answered to my satisfaction.

DO NOT SIGN UNTIL YOU READ AND UNDERSTAND THIS FORM.

I consent to the performance of blood testing to detect antibodies to the HIV virus.

Name_____ Date_____

*This sample consent form is intended as useful information for physicians and hospitals in their efforts to implement the AIDS legislation enacted in 1989. It is not intended, and should not be used, as a substitute for consultation with legal counsel.

Distributed as a service to physicians by the Medical Society of Virginia and the Virginia Hospital Association

Sample Form

NOTICE OF DEEMED CONSENT TO HIV BLOOD TESTING

(To be inserted in information admission forms or printed on a separate form supplied to patients before treatment is rendered)*

A law was enacted in Virginia in 1989 which authorizes health care providers to test their patients for HIV antibodies when the health care provider is exposed to the body fluids of a patient in a manner which may transmit human immunodeficiency virus (HIV). Pursuant to this law, in the event of such an exposure, you will be deemed to have consented to such testing, and to have consented to the release of the test results to the health care provider who may have been exposed. However, you would be informed before any of your blood would be tested for HIV antibodies pursuant to this provision, the testing would be explained, and you would be given the opportunity to ask any questions you might have.

I have read and understand the above "Notice of Deemed Consent to HIV Blood Testing."

Date_____ Patient's Signature_____

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transmit the virus. ***Notice to patients is required; consent is not.***

To be effective, except in emergency situations, this notice must be given prior to providing the patient with any health care services which create the risk of exposure. Accordingly, it is recommended that an appropriate notice be printed on the initial information/admission forms routinely used by physicians' offices at the time of the first patient visit. It is also recommended that the patient sign and date the notice as documentation that the notice has been given.

Reciprocity

The deemed consent provision described above is reciprocal in nature. It authorizes testing of health care workers when there is an exposure to their patients in a manner which may transmit the virus. Accordingly, although not expressly required, it may be a good idea for physician office practices and hospitals to provide a similar notice to their employees, if the employee is in a position to create a risk of exposure to patients.

Answering Questions

It is recommended that office personnel be made available to explain the statutory deemed consent provision, the notice and how the provision will be implemented in the office or hospital setting, should the patient have questions.

Explaining the Test

If there is an exposure which comes within the deemed consent provision, Virginia law requires that before testing the patient or health care worker he or she must receive an oral or written explanation of the meaning of the HIV testing process.

Disclosure/Counseling

Upon receipt of the test results, the patient or health care worker should be afforded an opportunity for individual face-to-face disclosure of the test results and appropriate counseling. This is required by Virginia law, whether or not the test is positive. It is recommended that health care providers document that the disclosure and counseling requirements have been met in the medical record and/or personnel file.

On Unification

In the following, M = MSV member; FM = former MSV member; NM = not a member.

Unification a disaster because it was not voted on by the membership. Why don't we reverse this? It would make those of us who are loyal members and have stayed on, taking the heat from others, feel better about the MSV. Just do it! *M*

If MSV and AMA were separate, I would be an MSV member today. *FM*

Don't tell me what organizations to join! *FM*

Unification was/is a very bad idea and will continue to weaken the MSV. I say this despite long membership in the AMA. *M*

Was proud to be MSV member for 30 yrs. Do not like compulsory AMA membership, thus reluctantly dropped out. Would send check to MSV any time unification is dropped. *FM*

If there was not unified membership. I probably would join, just because it is my state society. *NM*

MSV is doing a great job. I feel that the AMA is not doing as good a job as I would like to see. Unified membership policy should be rescinded. *M*

Had been a member since 1958. This is first year I declined. Remove unified membership. *FM*

Although I supported unified membership when it was passed, I no longer support it, and I may not continue my membership in the future. *M*

Though I am a member, I consider unified membership a form of extortion. *M*

If it were not for unified membership with AMA, I would join MSV. *NM*

I belonged, I was involved. I won't be dominated by the AMA, and I still don't believe what my Society did to many of its members. Reconsideration would be a whole new matter. *FM*

I do not feel membership in MSV should be linked to AMA. Our group of six physicians is considering dropping out. *M*

I am opposed to MSV/AMA unification. Every physician in my community who has not joined gave that as their primary reason. *M*

I sit on my state specialty board, and I can state that not one of the board is a member of the MSV because of unified membership, even though there is a tremendous interest on the part of Virginia physicians to participate in the issues addressed by the MSV. *FM*

Unified dues are ridiculous! *NM*

I had always belonged to both MSV and AMA, but the decision was made to unify without consulting the local membership first, and I don't want that kind of paternalism. *FM*

I am not sure how long my respect for the MSV will continue if it keeps pushing the AMA. *M*

Unification was the main reason I resigned from the MSV. *FM*

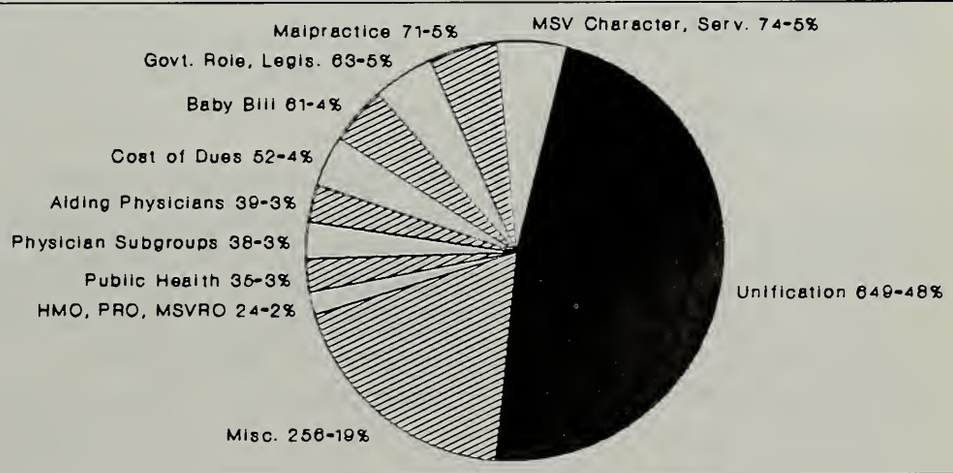

Fig. 1. Classification by Topic of Written Comments on 1,362 Responses to Physician Opinion Survey (22% of 6,237 Completed Surveys).

I harbor great resentment toward the MSV with regards to unification. This makes the MSV less accountable to individual physicians. ***M***

Reconsider MSV/AMA joint membership. I cannot afford to continue paying $800 plus a year. ***M***

MSV is too dictatorial. I want to be active in state society and have lots to contribute, but I do not wish to belong to AMA. ***NM***

MSV should remove AMA membership requirement and reinstate all who dropped out. FM

I belong to AMA only because of unified rule and because corporation pays. ***M***

Drop AMA! Go after the real problems: malpractice, government involvement, insurance control. ***FM***

Even though I formerly belonged to the AMA voluntarily, I very much resent the way MSV/AMA dues were bunched together without polling the membership. ***M***

An arrogant, serious mistake was made in combining MSV/AMA membership, and the results of this were predictable. ***M***

I will not join as long as unified membership is required. ***NM***

I totally oppose AMA membership rule and may very well resign over this issue. ***M***

Was a member until unified membership made it too costly. ***FM***

Disagree with unified membership. Should be free to join the organizations I wish and not coerced. ***M***

I quit MSV solely because of the requirement to belong to the AMA. I don't like being told which societies I have to belong to. I will not join again until the requirement is removed. ***FM***

I was a member of MSV, AMA, and VaMPAC when MSV voted for unified membership. As I result, I quit. ***FM***

On Cost of Dues

I am a member only because my group provides dues. ***M***

There is a limit to how much one can spend on professional societies. The state and specialty groups are more effective and take priority. ***FM***

Although I am a member of MSV/AMA, I believe the membership dues are too high, and this is what's keeping many physicians from joining. Are we getting our money's worth? ***M***

Cost/benefit ratio way out of line. ***M***

Decrease cost of dues to public health professionals (whose salaries are lower). ***NM***

Create special dues rate for full-time federal physicians. ***NM***

How about a dues reduction if both husband and wife are MDs and both want to be members? ***M***

Lower cost of dues for military doctors who have no private practice. ***NM***

As a solo pathologist based in a hospital, my costs are sky high and rising. I ask for special consideration for hospital-based physicians. ***M***

MSV is too expensive for most of us on medical school faculties. ***FM***

I'll stay a member regardless of the cost. The persons I've heard object the most are concerned with the high cost of unification. I think an accounting of monetary usage of my dues would be appropriate. ***M***

If I had a greater income, I would rejoin MSV. ***FM***

Lower dues. I understand your insistence on unified membership, but I have to choose my priorities. ***NM***

Did you ever consider that there are doctors who can hardly survive financially? ***NM***

I support MSV despite not being a member. I find costs of societies mount up (my specialty society is $600 per year), and I have to choose. ***FM***

I think medical societies are important for many reasons, but the dues are too expensive generally. My medical school loans are quite large. ***NM***

Unified membership has made many feel disenfranchised. *M*

It galls the hell out of me that legislation such as unified membership and assessment for brain-damaged newborns was passed without vote or approval of all MSV members. *M*

I was a member but when AMA became mandatory I was forced to drop out because I could not afford dues. *FM*

I understand your insistence on unified membership, but I have to choose my priorities. *NM*

Each year when it comes time to renew membership, I ask myself if it is worth the almost $1000 under unification. Any physician with proper medical credentials should be able to choose membership in any society without being forced to become a member of any other. This issue should be put to a vote of the general membership. *M*

No one ever discussed the MSV/AMA combination with me. I look at the money I'm paying for dues, and I'm ready to drop MSV/AMA and just read *JAMA* in the library. *M*

Abolish required AMA membership. *M*

I think the MSV prostituted itself in the agreement with the AMA and I'm not sure the hard feelings will be easy to forget. *FM*

I am about to resign over the unification issue. I also feel the Society has compromised with the legislature too much. *M*

I would join Medical Society of Virginia if it were not for unified membership dues. *NM*

AMA seems worthless to me. MSV not much better. *M*

Do not think unified membership should be required. I am for MSV membership. *M*

Drop unified membership, work to support primary care, keep dues low. *NM*

Recognize the mistake that unified membership really is. The old guard continues to buy the AMA hook, line and sinker. It needs to get beyond the good old boy network. *FM*

I feel very strongly that unification should have been submitted to a vote of the entire membership. *M*

On Injured Infants Act

After passage of mandatory $250 assessment for neurologically damaged infants, I have no faith that MSV will stand for what is right for physicians. *M*

Cancelled membership due to MSV activity over "bad baby" bill. *FM*

MSV is totally unresponsive to my needs, e.g., I now pay $250 per year so that the obstetricians can have malpractice insurance but it's not helping me a bit. *M*

Look at that $250 for all MDs for neurological defects and $5000 for OBs! Youall sold the store. Can you get it back? *M*

MSV did not inform us very well about bad baby bill. *M*

Bad baby bill a prime example of ineffective and/or misdirectional lobbying by MSV. *NM*

The most outrageous, tragic action of the MSV was to support the Virginia Birth-Related Neurological Injury legislation. This is reason enough never to join or support the MSV. *NM*

How can a medical society allow the bad baby bill when I do not deliver babies and have no intention of delivering babies. *M*

I am pissed off about your agreeing to the $250 assessment. It is the principle of it that is wrong. *M*

For the MSV to feel that the Injured Infants Act was a good deal for physicians is crazy! If this is what our leadership is doing for medicine, we are in real trouble. *FM*

Did a horrible job of neurological injury legislation—a real sellout. *M*

I strongly disagree with the MSV's role in the Injured Infants Act. This is ill-conceived legislation and poorly implemented. *M*

On the Survey

I thought this questionnaire was to deal with unification, which it has cleverly avoided. ***FM***

High time this study was made. Congratulations! Hope some changes come from it. Virginia MDs need to work together. ***NM***

Elements of this survey are redundant and confusing, particularly about belonging or not belonging to MSV/AMA. ***M***

It is important to ask members for their opinions and not just rely on the leaders for opinions. ***M***

These surveys should be conducted annually to determine what physicians are really concerned about. ***FM***

After 32 yrs of being a member, the MSV finally asked my opinion about something—if only what I think about the MSV. ***M***

Too many questions. The careful consideration of any questionnaire is inversely proportional to the number of pages. ***NM***

Thank you for making this relatively short and concise. ***M***

What a meaningless exercise. This vague statistics gathering is unnecessary. If you were doing your job the answers would be obvious. You got us where we are today. ***M***

Why not save some money and send this third class? ***FM***

This represents a good effort to open up the MSV to a wider participation. ***FM***

Purge leadership of all who supported unified (forced) membership and send written apology to all Virginia physicians. ***NM***

Drop unified membership and get rid of 'bad baby' law. ***NM***

Unification was a costly mistake. ***M***

My interactions with MSV have been few but always positive. The unified membership requirement put me off in principle—and it created a financial problem. ***FM***

Decision re joint MSV/AMA membership requirement was arbitrary and unjust and should be rescinded. ***M***

Eliminate unified membership. Lower MSV dues. Offer more attractive disability income insurance plan. ***NM***

I was a member of both MSV and AMA but resigned because unified membership was not presented to the membership. I do not think this was properly handled. ***FM***

I will probably resign if unification persists. ***M***

When the House voted not to allow the membership to decide unification, it indicated to me that the MSV was not interested in my opinion and I resigned. ***FM***

I would like to join the MSV but not the AMA. ***NM***

I cancelled my MSV membership when it joined the AMA. ***FM***

I am strongly against unified membership. This was 'railroaded' by a few and has been greatly detrimental to the MSV. ***M***

I believe in unification concept but high cost makes it out of my reach. ***NM***

Void unified membership. ***M***

I am seriously considering dropping out. Reason is unified membership, which in my opinion is not cost effective. ***M***

Abolition of the AMA requirement would resolve the conflict for most physicians I know. The AMA has the reputation, perhaps not deserved, of being self-serving and resistant to change. ***FM***

If the AMA were worthy of joining, coercion would not be needed. ***FM***

Who wants to spend $800 to unite with a losing group like the AMA? ***FM***

Put unified membership to written vote of all licensed physicians in Virginia. ***M***

Unification is why it took me so long to join! I don't like to be forced to join both if I don't want to. ***M***

I am happy with MSV but very much resent unified membership. ***M***

I was a member of MSV for many years until unified membership was forced on us. ***FM***

I object to mandatory MSV/AMA membership and plan not to renew. ***M***

Cost is a big factor. Eliminate requirement for AMA membership. ***NM***

Unified membership has done much to destroy the credibility of MSV with many practicing physicians. ***M***

I bitterly resent the unification decision taken without general referendum of the membership. My wife quit MSV for that reason. ***M***

Drop unified membership. I belong to the NMA. ***NM***

I opposed unified membership and my dues were returned and I had to change all my insurance. ***FM***

Dump the unification deal! I belong to both MSV and AMA because I want to, but many others will not join MSV if compelled to join AMA. ***M***

I belonged to both the MSV and AMA until youall made it mandatory. ***FM***

I would never join as long as membership in AMA is a required component. ***NM***

As one who has been an MSV and AMA member for all of my practice life, I say repeal unified membership. ***M***

The Medical Society of Virginia is an excellent organization to which I belonged until AMA membership became mandatory. The latter has been ineffective and poor in representing the physician. ***FM***

If I were allowed to vote on unified membership, I would join no matter how the vote came out. ***NM***

I wish to object again to forced MSV/AMA membership. I only continue in this double membership to assure my group health insurance coverage. ***M***

On Va Med

My only complaint [about MSV membership] is the poor literary and scientific quality of VIRGINIA MEDICAL. ***M***

Only benefit I get from MSV is VIRGINIA MEDICAL, and that hardly ever has anything interesting in it for the professional. ***M***

Have not been a member long enough (1 yr) so can't give an opinion about MSV, but I think VIRGINIA MEDICAL is well done. ***M***

As a former member, I think a journal subscription [membership] category would be interesting. ***FM***

Many publications of MSV/AMA are for many specialists. This is a waste. ***M***

MSV should make people of Virginia aware of its existence and role in insurance matters, take role in creating a good image about physicians, and send brief informative messages to members rather than useless monthly. ***M***

MSV does not have a decent state medical journal (like NC or NY). ***M***

Major role of MSV is its lobbying efforts. It contributes little else to medicine in Virginia—except the journal, which is good. ***M***

Long-term AMA member, joined MSV by force. Only MSV activity I see is numerous requests to buy things, take trips, and contribute money. VIRGINIA MEDICAL journal is good. ***M***

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Preliminary Program of The Medical Society of Virginia's 1989 Annual Meeting and the Annual Reports of Committees

Preliminary Program Medical Society of Virginia Annual Meeting 1989 November 8-12 Richmond Marriott

J. Thomas Hulvey, MD,
President,
The Medical Society of Virginia

Wednesday, November 8

4:00 PM
Council *Madison, Jefferson, Monroe Rooms*

Thursday November 9

9:30 AM
Hospital Medical Staff Section *Capital Room*

10:00 AM
State Legislative Committee *Madison Room*

10:30 AM
New Delegate Orientation *Monroe, Jefferson Rooms*

12 NOON
Past Presidents Luncheon *Dominion Room*

12:30 PM
Rules Committee *Salon 1*

1:30 PM
First Session, House of Delegates *Salons F-J*
George E. Broman, MD, Speaker
Lawrence K. Monahan, Vice Speaker

VaMPAC
6:30 PM: **Reception** *Salon 5*
7:30 PM: **Banquet** *Salons 1-4*
Keynote Speaker:
Thomas R. Reardon, MD, Commissioner,
Physician Payment Reform Commission

9:30 PM
President Hulvey's Reception *Salon 5*

Friday, November 10

7:30 AM
VaMPAC Board of Directors *Capital Room*
Federal Legislative Committee *Salon 6*

9:00 AM
Reference Committee One *Salons 1-3*
Reference Committee Two *Salon 4*
Reference Committee Three *Salon 5*

11:30 AM
50-Year Club Reception *Dominion Room*

Saturday, November 11

11:00 AM
Second Session, House of Delegates *Salons F-J*
Medical Society of Virginia

6:30 PM: **Reception** *Grand Ballroom Foyer*
7:30 PM: **Banquet** *Salons A-E*
President J. Thomas Hulvey, presiding

In an encore of his enthusiastically received performance at the 1988 meeting, Walter Noona will lead his Virginia Beach Pop Orchestra after the banquet, and the Walter Noona Trio will play for late evening dancing.

Scientific Program

Friday, November 10 (12:30 to 5 pm)
Salons 6-8

Leslie E. Rudolf, MD, Moderator

12:30 PM: **Who Will Meet Tomorrow's Nursing Needs?** Mrs. Anne MacCallum, Virginia Nurses Association; Ms. Patricia Cushnie, Virginia Hospital Association; and William W. Regan, MD, Richmond. Moderated by John A. Owen, Jr., MD, Charlottesville.

1:30 PM: **Geriatric Psychopharmacology.** P. Trey Sunderland III, MD, Chief, Unit on Geriatric Psychopharmacology, National Institute of Mental Health, NIH, Bethesda, Maryland. Moderated by Richard W. Lindsay, MD, Charlottesville.

2:30 PM: Recess to visit Exhibit Hall.

Guest Speaker Sunderland

Guest Speaker Rasmussen

3:00 PM: PAIN MANAGEMENT

Postoperative Pain Management. John C. Rowlingson, MD, Charlottesville.

Pharmacology of Pain. Mark Lehman, PharmD, School of Pharmacy, Medical College of Virginia/VCU, Richmond.

Pain Management in the Cancer Patient. Gerald Goldstein, MD, Charlottesville.

4:00 PM: **Ethical and Legal Aspects of Decisions to Forego Life-Sustaining Treatment in Virginia.** John C. Fletcher, PhD, Professor of Biomedical Ethics, and Elizabeth S. Scott, JD, Associate Professor of Law, University of Virginia, Charlottesville.

Saturday, November 11 (8 am to noon)
Salons 6-8

George W. Burke III, MD, Moderator

8:00 AM: **What's New in Pediatric Dermatology** (Lingamfelter Lecture). James E. Rasmussen, MD, Professor of Dermatology and Pediatrics, University of Michigan School of Medicine, Ann Arbor.

9:00 AM: OPHTHALMOLOGY FOR THE NON-OPHTHALMOLOGIST.

Systemic Effects from Topical Ophthalmic Drops. Robert C. Allen, MD, Charlottesville.

The Eye and Diabetes. Joseph J. Timmes, Jr., MD, Department of Ophthalmology, Georgetown University School of Medicine, Washington DC.

10:00 AM: Recess to visit Exhibit Hall.

10:30 AM: **Gallstone Lithotripsy, an Update.** James F. Lind, MD, Norfolk.

The Annual Scientific Program is developed by The Medical Society of Virginia in conjunction with Eastern Virginia Medical School, the Medical College of Virginia/Virginia Commonwealth University, and the University of Virginia School of Medicine. The Medical College of Virginia designates this program for 6.5 credit hours.

Scientific Exhibits

Current Status of Lipoplasty (Fat Suction). Richard A. Mladick, MD, Virginia Beach.

Diagnosis of Deep Vein Thrombosis. Comparison of Noninvasive Techniques and Venography. Robert E. Berry, MD, Jeffrey E. George, MD, Mark O. Smith, MD, and William A. Shaver, MD, Roanoke.

Imaging in Cancer. American Cancer Society, Virginia Division.

Organ/Tissue Donation: Update on Routine Contact Laws. Virginia Transplant Council.

Outpatient Cardiac Drug Intervention, C.L. Baird, Jr., MD, Richmond.

The Use of Autologous Fibrin Glue in Anchoring Small Skin Grafts. Ranes C. Chakravorty, MD, Salem.

The Virginia High School League Preparticipation Physical Evaluation. Vito A. Perriello, Jr., MD, Charlottesville.

Unna Boot: Indications and Technique. Robert E. Berry, MD, and William A. Shaver, MD, Roanoke.

Virginia Spinal Cord Injury System. Janet B. Downs, RN, Fishersville.

At locations in the registration area or the Grand Ballroom foyer, members of the Medical Society of Virginia Auxiliary will have an exhibit on AMA-ERF and representatives of Travelers Medicare and Cambridge Financial Services will be available to answer questions.

Special Events

Thursday, November 9

American College of Emergency Physicians, Virginia Chapter
5:00 PM: Reception — *Monroe Room*

Friday, November 10

Virginia Society of Internal Medicine
7:30 AM: Breakfast — *Monroe Room*

Virginia Urological Society
7:30 AM: Breakfast — *Madison Room*

American College of Physicians, Virginia Chapter, Council
12:00 NOON: Luncheon — *Monroe Room*

Virginia Society of Ophthalmology
12:00 NOON: Luncheon — *Jefferson Room*

American Association of Public Health Physicians, Virginia Chapter
12:00 NOON: Luncheon — *Madison Room*
2:00 PM: Scientific Session — *Salons 1-3*

Exhibit Hall

Salons A-E
Friday, November 10; 8 am-5 pm
Saturday, November 11; 8 am-1 pm

Clinical Support
American Homecare Equipment, Inc.
BFI Medical Waste Systems
Hagen & Humbert, Inc.
Incendere, Inc.
Institute for Low Back Care
Riverside Laboratories
Roche Biomedical Labs, Inc.
Southeastern Hospital Supply Corp.

Collections
I.C. System, Inc.

Computerization
Elcomp Systems
Medic Computer Systems
Medical Technologies, Inc.
Sentient Systems, Inc.
SouthEast Medical Computer Systems

Education
Encyclopaedia Britannica USA
W. B. Saunders Company

Hospitals
Mountain Wood/Regional Services
Roanoke Valley Psychiatric Center
Saint Albans Psychiatric Hospital

Pharmaceuticals
Abbott Laboratories
A. H. Robins Company
Allen & Hanburys (Division of Glaxo)
Boehringer Ingelheim Pharmaceuticals
Daniels Pharmaceuticals, Inc.
Dupont Pharmaceuticals
Janssen Pharmaceutica
Mead Johnson Pharmaceuticals
Merck Sharp & Dohme
Merrell Dow Pharmaceuticals
Miles, Inc., Pharmaceutical Division
Pfizer Laboratories
Roerig Pharmaceuticals
Ross Laboratories
Schering Corporation
G. D. Searle & Co.
Smith Kline & French
Stuart Pharmaceuticals
The Boots Company (USA), Inc.
The Upjohn Company

Protection
Clements & Company
Equicor Health Plan, Inc.
Haycraft Insurance Agency, Inc.
Insurance Corporation of America
John P. Pearl & Associates
Medical Protective Company
The St. Paul Companies
Virginia Insurance Reciprocal

Recruitment
United States Army

Virginia Obstetrical/Gynecological Society
12:30 PM: Luncheon — *Capital Room*

The Upjohn Company
5:30 PM: Reception — *Board Room, 18th Floor*

Eastern Virginia Medical School Alumni
6:00 PM: Reception — *Capital Room*

University of Virginia Medical Alumni Association
6:00 PM: Reception — *Salons I-J*

Bowman-Gray School of Medicine Alumni Association
6:00 PM: Reception — *Dominion Room*

Medical College of Virginia Alumni Association of VCU
6:30 PM: Reception — *Salon F*
7:30 PM: Dinner — *Salon F*

Saturday, November 11

Virginia Orthopaedic Society
7:30 AM: Breakfast — *Monroe Room*

Virginia Society for Pathology
7:30 AM: Breakfast — *Jefferson Room*

Virginia Pediatric Society Executive Committee
7:30 AM: Breakfast — *Madison Room*

Psychiatric Society of Virginia
9:00 AM: Scientific Session — Salons 1-3
12:00 NOON: Luncheon — Salon 4

Virginia Society of Otolaryngology Board of Directors
11:00 AM: Meeting — *Board Room, 18th Floor*

American College of Radiology, Virginia Chapter
10:30 AM: Meeting — *Capital Room*
12:00 NOON: Luncheon — *Jefferson Room*

Virginia Allergy Society
12:30 PM: Luncheon — *Dominion Room*

Virginia Society of Anesthesiologists
10:30 AM: Meeting — *Monroe Room*
12:30 PM: Luncheon — *Monroe Room*

Virginia Society of Physical Medicine and Rehabilitation
12:30 PM: Luncheon — *Madison Room*

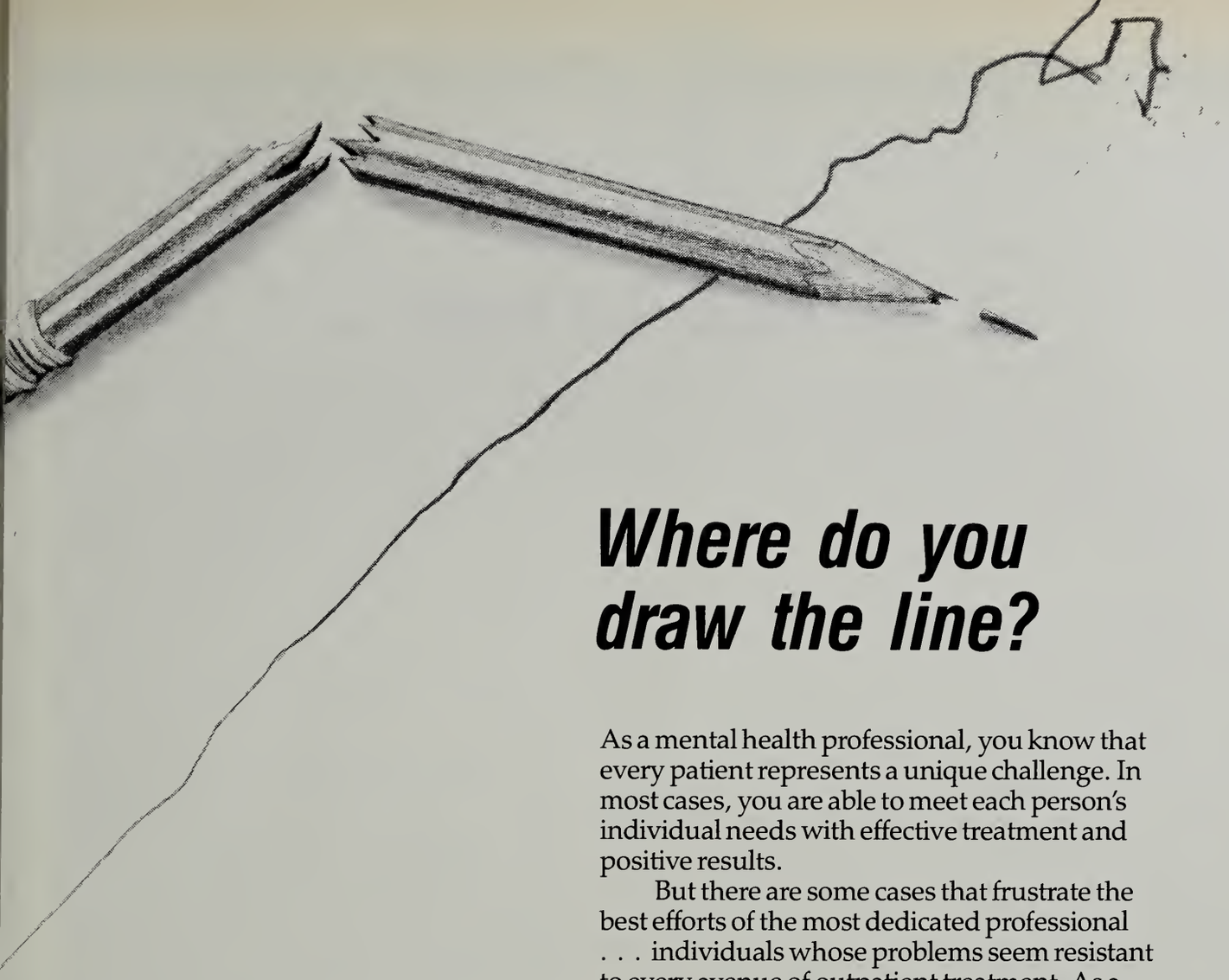
Virginia Dermatological Society
4:00 PM: Scientific Session — *Salons 1-3*
6:30 PM: Reception — *Madison, Monroe, Jefferson Rooms*

Sunday, November 12

Virginia Dermatological Society
9:00 AM: Scientific Session — *Salons 1-3*

Recreation

Both tennis and golf tournaments are to occur on Friday, November 10, on the Westhampton links and courts of the Country Club of Virginia. Dr. William W. Regan is making the golf arrangements. Dr. Benjamin R. Allen, Jr., is working up the tennis agenda.

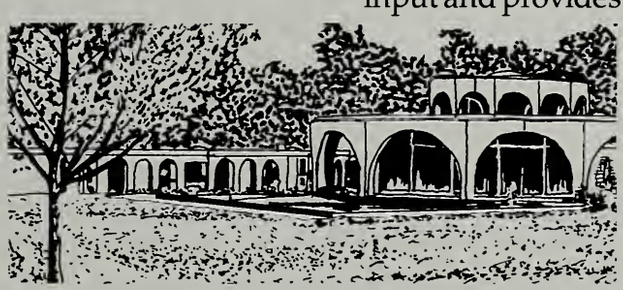


Where do you draw the line?

As a mental health professional, you know that every patient represents a unique challenge. In most cases, you are able to meet each person's individual needs with effective treatment and positive results.

But there are some cases that frustrate the best efforts of the most dedicated professional . . . individuals whose problems seem resistant to every avenue of outpatient treatment. As a concerned professional, where do you draw the line between giving patients your best and drawing on the inpatient resources of others?

For more than 80 years, Taylor Manor Hospital has provided welcome support to fellow professionals faced with the patient in need of our inpatient setting. Our multi-disciplinary approach welcomes your input and provides a broad base of psychiatric services, including specialized treatment programs for adolescents, adults, young adults, addictive behaviors, and members of the ministering profession.



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A Few Important Issues

Our President, Dr. J. Thomas Hulvey, said many times this year when addressing component societies, "I am not going to give you a speech, I am just going to talk with you about a few important issues." That is exactly what this year has been all about—a few important issues.

We addressed the internal workings and policies of the Medical Society of Virginia so we could take stock objectively of where the Society must move ahead. Dr. Hulvey led the leadership and headquarters staff in what became a period of tough and sometimes painful internal evaluation. Through the Physician's Opinion Survey we asked our members, former members, and those Virginia physicians who have never been members, what they thought. We got straight answers, and we listened. We have already made some changes and others are in the making.

From the 11,800 physicians polled by the survey, we received over 6,000 returns—a remarkable response. Of all the comments in those returns, I was particularly distressed by the MSV members who said they are not familiar with the Medical Society of Virginia's activities and benefits. The April 1987 cover of Virginia Medical featured an MSV stock certificate; a "Report to the Shareholders" inside the issue listed 38 dividends of membership. That report has been updated, and I have asked the Editors to include the new version in this issue.

Actually, the overriding issue revealed by the survey was unification. I can assure you that the Council will be made fully aware of that and all other survey findings and no doubt will make some recommendations to the House of Delegates.

I am pleased to report that the Task Force studying the Injured Infants Act has been working hard to set the stage for a reversal of the $250 physician's assessment, and we hope to get some relief during the coming session of the General Assembly.

Improving communications is always a challenge, and we have developed a system to notify the membership within a one-day period.

We published *Med Alert* on two occasions, addressing expenditure targets and the nurse practitioner issues. A *Closing Your Practice* packet developed by the Public Relations Committee has been very well received. The Society sent out over 50 mailings during the past year, to the entire membership or part of the membership. Let us know how we can better communicate with you.

We have been working hard on membership recruitment, but it has been most difficult. I regret to report that it appears that upwards of 300 members are not going to renew their memberships this year; we won't know the exact figure until the end of the fiscal year September 30. As the table below shows, we continue a net loss in our membership figures.

Membership Report

August 1, 1988		5,880
New Members		318
Reinstated		29
Deaths	39	
Resignations	76	
Dropped	323	
		347
Net Decrease		91
July 31, 1989		5,789

4,573	Active
14	Past Presidents
247	Associates
41	Residents
914	Dues Exempt
5,789	

The Society now has on its rolls less than half the physicians in the Commonwealth. Letters of invitation to join the Society are not the answer—we need one-on-one contact. A new approach to recruiting is in the planning stages. For it we will need the support of every member.

There are so many complex issues facing medicine today that it is almost impossible to keep up with them. Nobody tries harder to stay on top of the important issues than the Society's committees, and the annual reports in these pages are evidence of their dedication and hard work. I encourage all of you to read them.

James L. Moore, Jr.,
Executive Vice President,
The Medical Society of Virginia

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Aging

COMMITTEE ON AGING

Considers legislation affecting the elderly. Works with the State Department in Aging in reviewing its programs. Acts in an advisory capacity to the Governor's Advisory Board on Aging.

John A. Owen, Jr., MD, Charlottesville, Chairman
H. C. Alexander III, MD, Roanoke
Richard W. Lindsay, MD, Charlottesville
Eugene W. Overton, MD, Fairfax
Samuel E. Miller, MD, Abingdon
Helen Wood, Richmond, Student

Responding to the actions of the 1988 House of Delegates, component medical societies across the state have made significant progress toward the goal of 100% participation in voluntary programs for the acceptance of Medicare assignment based on need.

As of July 7, the progress report read as follows: 1) operational programs in place, 11 societies; 2) program in active planning stage, 4; 3) program under consideration, 4; not under consideration, 5; no report, 22.

The committee will continue individual discussions with the 27 societies in the last two categories. In 1990 it will turn its attention to some of the other major health problems of the aging segment of our population.

John A. Owen, Jr., MD

Alternative Delivery Systems

COMMITTEE ON ALTERNATIVE DELIVERY SYSTEMS

Acts as a clearing house for information about alternative delivery systems. Provides resource guidance, consultation, experience pooling, and grievance channeling.

Leon I. Block, MD, Falls Church, Chairman
John M. Daniel III, MD, Richmond
Edwin J. Harvie, MD, Danville
John W. Hollowell, MD, Portsmouth
John P. Kaufman, MD, Roanoke
David N. Tornberg, MD, Newport News
Jeffrey W. Wilson, MD, Roanoke
Sam Said Keblawi, Norfolk, Student
Matt Member, Charlottesville, Student

Recommendation

That the Medical Society of Virginia petition the Insurance Commissioner of Virginia to utilize his office to secure the voluntary compliance of all entities carrying out Prior Authorization Programs in the Commonwealth of Virginia with the guidelines developed jointly by the AMA, the National Blue Cross and Blue Shield Association, and the Health Insurance Association of America.

There is great variation and inconsistency in the structure and operation of Prior Authorization Programs. Some of these are operated by insurance carriers themselves. Others are operated by administrators acting on behalf of carriers or self-insured entities. These independent health benefits administrators currently do not fall under the purview of any governmental agency. The Committee is presently studying guidelines for administration of "Prior Authorization" and "Claims Submission and Review" programs by third-party carriers and managed care administrators. A set of voluntary guidelines has been adopted by the AMA, the National Blue Cross and Blue Shield Association, and the Health Insurance Association of America. To be considered is whether these voluntary guidelines will be sufficient or whether legislation mandating compliance will be necessary if voluntary action fails.

General

The Committee notes with satisfaction the passage of an HMO guaranty funding measure by the Virginia Legislature. A resolution proposing this was passed by the Medical Society of Virginia House of Delegates in 1988. The issue was subsequently championed by Insurance Commissioner Foster to protect our patients in the event of financial failure of an HMO to which they subscribe.

Leon I. Block, MD

COMMITTEE ON AIDS

Keeps abreast of new treatment/ management methods, works with the State Department of Health in formulating policy, and provides public information on the disease.

Donald M. Poretz, MD, Annandale, Chairman
Richard S. Buddington, MD, Abingdon
Lisa Kaplowitz, MD, Richmond
Richard L. Keeling, MD, Charlottesville
Grayson Miller, MD, Richmond
Leslie E. Rudolf, MD, Charlottesville
Harold L. Williams, MD, Newport News
Thomas N. Wise, MD, Falls Church
Lawrence D. Jones, MD, Lynchburg, Adviser
Jack Schneider, Richmond, Student

ANIMAL RESEARCH COMMITTEE

Apprises The Medical Society of Virginia of potential problems in the use of animals in research, especially legislation seeking to curtail or eliminate animal research.

C. Barrie Cook, MD, Falls Church, Chairman
Gary D. Hodgen, PhD, Norfolk
Dearing W. Johns, MD, Charlottesville
John A. Owen, Jr., MD, Charlottesville
Nicholas J. Sojka, Jr., DVM, Charlottesville
George W. Vetrovec, MD, Richmond

AUXILIARY ADVISORY COMMITTEE

Serves in an advisory capacity to the president of the Auxiliary.

J. H. Hollingsworth, MD, Roanoke, Chairman
William S. Hotchkiss, MD, Virginia Beach
Glenn B. Updike, Jr., MD, Danville

BYLAWS COMMITTEE

Considers all proposed bylaws amendments. Suggests necessary revisions and interprets provisions in case of conflict.

Robert L. A. Keeley, MD, Roanoke, Chairman
George E. Broman, MD, Culpeper, Speaker
Lawrence K. Monahan, MD, Roanoke, Vice Speaker
Robert L. Cassidy, MD, Norfolk
Custis L. Coleman, MD, Richmond
Antonio M. Longo, MD, Alexandria
William W. Regan, MD, Richmond
Kevin B. Kaiserman, Norfolk, Student

Animal Research

During the past year the Animal Research Committee has not had any formal meetings, although your chairman and Dr. John A. Owen, Jr., have been very active. They have met on three or four occasions with Dr. Kenneth Enders of the Medical College of Virginia and other members of the academic community in regard to the legislation that was considered by the 1989 General Assembly.

Your chairman also met with Delegate Ken Plum, who was chairman of a study commission for the General Assembly on this subject. Dr. Owen and I also testified before one of the committee hearings, and Dr. Owen arranged for various patients and/or their families to also appear.

The legislation passed in regard to the use of animals in research ended up being labelled as a "pet protection" bill. In its present form, it does not prohibit the use in research of animals from pounds unless they have been tattooed or identified in some way as a pet.

C. Barrie Cook, MD

Auxiliary Advisory

The Medical Society of Virginia Auxiliary continues to be very productive and had another successful year involving many activities.

For the first time, three state board auxilians were appointed by the President to serve as special advisers to the Public Relations Committee. This committee has made great strides during the year and we know these appointees added to the deliberations.

Seminars on AIDS, teenage self-esteem forums, health fairs, Meals-on-Wheels, and nursing home visits with pets are a few projects that were conducted by the Auxiliary throughout the state. The Auxiliary can be proud of its leadership role in developing the state-mandated Family Life Education Program.

The contributions to the AMA-ERF were over $50,000—well ahead of last year's total. Virginia's three medical schools benefitted, with the funds designated for both student assistance and academic programs.

The Auxiliary changed its annual meeting date to the spring of the year and had a very successful meeting in May but will continue to meet during the annual MSV meeting by holding a board meeting at that time.

The Advisory Committee congratulates the Auxiliary on an outstanding year of growth and achievement.

J. Hayden Hollingsworth, MD

Bylaws

Recommendation

That the House of Delegates continue to follow Sturgis in regard to determining the legality of ballots (Sturgis Standard Code of Parliamentary Procedure, 3rd Edition, pp 147-8).

General

During the last session of the House of Delegates, in November, 1988, the issue was raised concerning a valid ballot. The Bylaws Committee was asked to consider the possibility that a valid ballot should have the exact number of names in accordance with the number to be elected.

Robert L. A. Keeley, MD

Cancer

Recommendation:

That the Medical Society of Virginia support appropriate legislation in the 1990 General Assembly which has the intent of requiring "clean air" in the private work place as well as in the public work place and in places of public assembly.

The role of passive smoking as a carcinogenic exposure is now well demonstrated by epidemiologic studies, hence the Committee advises the above support in the best interest of cancer control.

General

The Committee met on March 1 and on September 27 for the discussion of legislation and of educational programs.

The Committee was successful in obtaining 1989 General Assembly support for and passage of HB 1449—Insurance Coverage for Screening Mammography—whereby third party payers are required to make available coverage for screening mammography which meets well-defined guidelines. Members participated in the ceremonial signing of this bill by Governor Baliles on April 20.

The Committee performed an important role in the passage by the General Assembly of HJR 331, a resolution requesting the State Council for Higher Education to study the feasibility of developing educational alternatives for cytotechnologists and to report by January 1, 1990. The acute shortage of cytotechnologists is already being experienced throughout the Commonwealth.

The Committee worked closely with the American Cancer Society in coordinating educational objectives and will sponsor a joint one-hour program on pain management in cancer at the 1989 annual meeting of the Society.

Robert J. Faulconer, MD

Editorial Board

Composing a different annual report of the same general procedures and events poses a problem. VIRGINIA MEDICAL continues to provide the readership with a mix of politics, medical news, scientific articles and editorial comment, with the continuing aim of something for everyone. In the main, this goal seems to be accomplished; at least, the letters support this assertion.

The Editorial Board, contributors, and our efficient staff continue to shine, and for this we are most grateful.

E. L. Kendig, Jr., MD

Education

For the second year, the Education Committee held an educational program for Directors of Medical Education of state accredited organizations, their assistants, and representatives from organizations interested in accreditation. The program was held in conjunction with the Annual Meeting at the Williamsburg Conference Center. It focused on the organization of CME in the United States and Virginia, drawing special attention to accreditation policies and procedures of The Medical Society of Virginia.

In response to the needs of accredited organizations, a policy has been developed by the MSV accreditation program on providing consultation to accredited sponsors. Several organizations have contacted the CME office to receive information and consultation.

Seven hospitals and organizations have been resurveyed for renewal of accreditation since last annual re-

CANCER COMMITTEE

Works closely with the American Cancer Society, Virginia Division, in reviewing its detection and education programs. Is concerned with development and improvement of tumor registries and cancer center activities over the state.

Robert J. Faulconer, MD, Norfolk, Chairman
Richard Belgrad, MD, Richmond
James W. Denton, MD, Abingdon
Wayne W. Ferguson, MD, Virginia Beach
Arthur B. Frazier, MD, Roanoke
Fred T. Given, Jr., MD, Norfolk
Gerald Goldstein, MD, Charlottesville
John J. Halpin, MD, Lynchburg
J. Shelton Horsley III, MD, Richmond
Walter Lawrence, Jr., MD, Richmond
Grayson B. Miller, Jr., MD, Richmond
William J. Munsie, MD, Fredericksburg
William W. Old III, MD, Lexington
Max B. Rubin, MD, McLean
R. B. Seal, MD, Portsmouth
Winston M. Ueno, MD, Alexandria
Robert L. White, MD, Great Falls
Sherry Sackett, Glen Allen, Adviser
Bobbie Camden, Charlottesville, Student

CHILD HEALTH COMMITTEE

Considers all aspects of child health in Virginia, with particular emphasis on legislation involving safety.

Jefferson D. Beale, Jr., MD, Danville, Chairman
Thomas S. Chalkley, MD, Richmond
H. William Fink, MD, Norfolk
Duane A. Lawrence, MD, Virginia Beach
Carolyn M. McCue, MD, Richmond
Delosa A. Young, MD, Springfield
Douglas E. Pierce, MD, Roanoke
James H. Stallings, Jr., MD, Falls Church
Janet Allen, Norfolk, Student

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Determines policies for VIRGINIA MEDICAL.

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John A. Owen, Jr., MD, Charlottesville
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Raymond S. Brown, MD, Gloucester
Henry S. Campell, MD, Martinsville
C. Barrie Cook, MD, Fairfax
Eloise C. Haun, MD, Woodstock
Walter Lawrence, Jr., MD, Richmond
Lockhart B. McGuire, MD, Charlottesville
Robert Edgar Mitchell, Jr., MD, Richmond

EDUCATION COMMITTEE

Serves as the center of continuing medical education activity in Virginia. Is concerned with accreditation of hospital and other organizations. Documents attendance and develops criteria for The Medical Society of Virginia's mandatory CME program.

J. Albert Hagy, MD, Rocky Mount, Chairman
W. Jackson Helm, MD, Winchester, Vice Chairman
Charles H. Crowder, Jr., MD, South Hill
Thomas L. Moffatt, MD, Richmond
Michael A. Moore, MD, Danville
Anthony J. Munoz, MD, Farmville
Frederick W. Parker III, MD, Manassas
Herman H. Pinkerton, Jr., MD, Abingdon
R. Lawrence Smith, MD, Virginia Beach
Emanuel Stein, MD, Norfolk
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Donald S. Thorn, MD, Annandale
Oscar A. Thorup, Jr., MD, Charlottesville
Reuben B. Young, MD, Richmond
Kinloch Nelson, MD, Richmond, Adviser
Paul Mazmanian, PhD, Richmond, Adviser

ELECTRONIC BILLING COMMITTEE

Purpose is to assess the feasibility of electronic billing for the Society.

Charles M. Caravati, Jr., MD, Richmond, Chairman
C. Barrie Cook, MD, Falls Church
Nelson N. Isenhower, MD, Winchester
William W. Regan, MD, Richmond
Helmuth W. Trieshmann, MD, Newport News
J. Latane Ware, MD, Richmond

EMERGENCY MEDICINE COMMITTEE

Is responsible for continuing study of emergency medical care throughout Virginia.

John P. McDade, MD, Alexandria, Chairman
Robert L. Barth, MD, McLean
Mark P. Davis, MD, Oakton
Stanley E. Heatwole, MD, Staunton
Robert A. Kravetz, MD, Fredericksburg
Michael T. Rapp, MD, McLean
Gaylord W. Ray, MD, Gloucester
Leslie E. Rudolf, MD, Charlottesville
Francis Watson, MD, Chesapeake

port. Two were granted 4 years full accreditation, two were granted 2 years full accreditation and one received two years probationary accreditation. A final decision is pending on the two most recently surveyed hospitals.

Focused education for those found deficient through evaluation of physician performance has been of national concern this year. Dr. Paul Mazmanian, Education Advisor, attended the Planning Conference on Focused/Prescribed/Remedial Education for Enhanced Clinical Competence held in January 1989 in San Francisco. He has met with the Committee to discuss the subject and the specific needs for support of a system to provide such services. Your Chairman and Vice Chairman attended the annual AMA-ACCME CME Conference in Orlando, Florida in May which also addressed this subject. The formation of a committee to study focused CME for enhanced clinical competence, consisting of representatives from several of the Society's committees and other organizations, was suggested to Council.

Alphabetical Group I of the membership reported their continuing medical education credits for 1986-88 this year. This group consists of 1693 physicians. There remain 29 who had not submitted a report by August 10, 1989.

These are the currently accredited hospitals and organizations in Virginia: American Cancer Society (Virginia Division), Community Hospital of Roanoke Valley, Eastern Virginia Medical School, Fairfax Hospital Association, Lewis-Gale Consortium, Medical College of Virginia/VCU, Northern Virginia Consortium for CME, Potomac Hospital, Riverside Hospital, Roanoke Memorial Hospital, Memorial Hospital, University of Virginia, Virginia Beach General Hospital, Virginia State Health Department and Winchester Medical Center.

J. Albert Hagy, MD

Electronic Billing

Recommendations

1. That for the present the Medical Society of Virginia not attempt to initiate an electronic billing service but that we encourage vendors to consider entering the market;

2. That talks be initiated in the immediate future with representatives of Blue Cross/Blue Shield regarding the electronic billing issue and that they be continued on a regular basis;

3. That we develop some sort of system to keep track of the time required for payment of paper claims;

4. That we urge Blue Cross/Blue Shield to use the information they receive from Medicare on explanation of benefits to pay claims;

5. That we alert hospitals to the fact that information from Blue Cross/Blue Shield data may be sold to their hospitals and that hospital staffs should make every attempt to ensure that they are notified when such a transaction takes place;

6. That the Medical Society of Virginia continue to monitor Blue Cross/Blue Shield activities and be prepared to take any steps that may be deemed important for a reasonable resolution of the problems concerned with electronic billing.

These recommendations were formulated at a meeting of the Electronic Billing Committee on June 28, 1989.

Charles M. Caravati, Jr., MD

DEPRESSION

Depression is only one emotional illness we treat at Tucker Pavilion. Our comprehensive facility includes inpatient and outpatient chemical dependency programs, eating disorders and a geriatric medical unit. Because we are part of Chippenham Hospital, medical and surgical care is available for patients.

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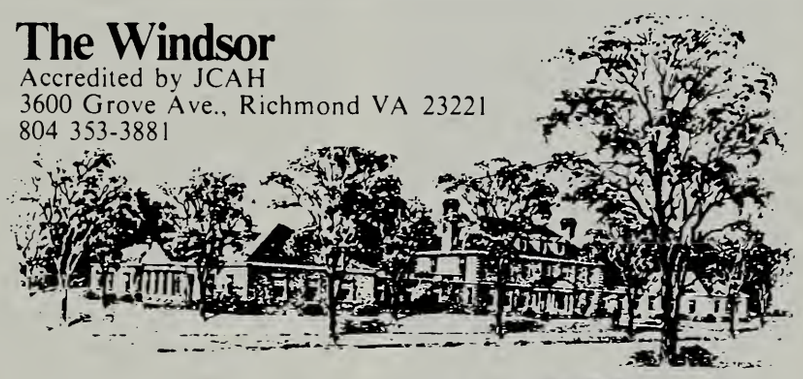

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804 353-3981

University Park

Accredited by JCAH
2420 Pemberton Rd., Richmond VA 23233
804 747-9200

ETHICS COMMITTEE

Is concerned with all matters involving ethics and conduct of Medical Society of Virginia members. Considers individual cases on appeal from component societies.

Robert E. Mitchell, Jr., MD, Richmond, Chairman
Thomas M. Fulcher, MD, Falls Church
F. Bradley Gray, MD, Fredericksburg
Edwin J. Harvie, MD, Danville
Gervas S. Taylor, Jr., MD, Nellysford
Philip J.M. Candilis, Washington DC, Student

FEDERAL LEGISLATIVE AND ACTIVITIES COMMITTEE

Serves as medicine's watchdog in problem areas, especially where legislation is concerned. Recommends courses of action to meet perceived challenges.

Norman R. Edwards, MD, Newport News, Chairman
H. C. Alexander III, MD, Roanoke
Robert M. Allen, MD, Falls Church
John Boniface, Jr., MD, Fredericksburg
George E. Broman, MD, Culpeper
William W. S. Butler III, MD, Roanoke
George B. Craddock, Jr., MD, Charlottesville
Charles H. Crowder, Jr., MD, South Hill
John M. Daniel III, MD, Richmond
Michael E. Davidov, MD, Falls Church
Jamison K. Francis, MD, Woodbridge
Ira J. Green, MD, Alexandria
William J. Hagood, Jr., MD, Clover
Clarence A. Holland, MD, Virginia Beach
John W. Hollowell, MD, Portsmouth
Alfred J. Martin, Jr., MD, Suffolk
Frederick K. McCune, MD, Virginia Beach
C. M. Kinloch Nelson, MD, Richmond
Larry H. Redmond, MD, Lynchburg
James A. Smith III, MD, Lynchburg
James Hal Smith, MD, Christiansburg
Thomas M. Stiles, MD, Newport News
Jack C. Turner, MD, Danville
Percy Wootton, MD, Richmond
Mrs. George Bazaco, Richmond
Patricia Lanter, Richmond, Student

Ethics

The Ethics Committee members have had a busy and interesting year. Decisions:

1) Physicians should not be required to release confidential data regarding their patients to a health care plan or other agency without specific written approval by the patient.

2) Ms. Sandra Kramer, legal counsel to the Society, is obtaining information from the American College of Surgeons and the American Medical Association as to the ethics involved in physician ownership of health facilities. This is forthcoming. It is part of the Legislative Committee's request, via Council, for the Ethics Committee to develop MSV policy related to the practice by physicians of receiving income from medical services other than professional services, especially through joint ventures and captive referrals.

3) The Ethics Committee is interested in sending to all physicians in the Commonwealth a copy of the *Principles of Medical Ethics*—ready for framing—and hope it will be displayed prominently in each medical office across the state.

4) The Committee feels strongly that the groundwork for morals and ethics should begin in grammar school and be continued through all levels. We believe that people at every level can be trained to think about ethical dilemmas.

5) The three schools of medicine located in the Commonwealth of Virginia should each have full time Ethics Departments, with instructions in all four years. Graduate students and house officers should also have regular instructions in ethics.

6) All Virginia hospitals should have regularly meeting ethics committees or at least a staff ethics consultant. The American Medical Association now reports 90% of the country's major hospitals have one or the other. The goal is 100%.

7) The Committee strongly condemns medical "kick-back" schemes whereby the middle man receives remuneration for directing customers to certain medical supply houses who in turn bill Medicare and other insurance companies.

8) Fraudulent medical literature should be prosecuted to the full extent of the law by the Attorney General or other Commonwealth legal officer. The Executive Director of the State Board of Medicine has stated that unless the offending party holds a license issued by the Board or other state medical related regulatory board, it would not have jurisdiction and the Attorney General's office would be best equipped to handle the matter.

9) Ethicists are arriving on the medical scene strongly. An occasional difficult case from an ethical standpoint is helped by having a trained ethicist to help in deciding not only the morality involved but also to assist in sorting out the liability concerns of physicians as well as hospitals. As Dr. James Joyce, Jesuit priest in Manhattan says, "Ethics is red hot right now."

Robert Edgar Mitchell, Jr., MD

Federal Legislative/Activities

The Committee reviewed, strongly supported, and recommended to Council that the resolution on quality of care denials adopted by the MSV House of Delegates in November, 1988, be submitted to the AMA House of Delegates meeting in June, 1989.

The Committee recommended to Council that it authorize the dissemination of information to the membership regarding compliance with the law in the use of ICD-9 codes (in view of the failure of HCFA to notify carriers and physicians in timely fashion of coding requirements). The Committee also recommended to Council was strong opposition to expenditure targets—modeled after the Canadian system—as proposed by the Physician Payment Reform Commission (PPRC) when consideration is given to budgetary cuts or controls in Medicare spending.

The Committee supported a resolution concerning monetary limits in modification of reporting require-

ments of the National Physicians Registry.

A prepared statement signed by Dr. Hulvey and endorsed by the Committee was sent to the Subcommittee on Labor, Health and Human Service and Education in support of biomedical research.

The Committee will continue to monitor carefully the recommendations of the PPRC and will welcome any comments on this issue from the membership. Additionally, we would be happy to serve as a conduit for any anecdotal information concerning "self-referral" or regarding difficulties in dealing with Medicaid or Medicare (red tape vs fees paid) by relaying such information to the AMA Legislative Section.

Norman R. Edwards, MD

Highway Safety

The 1988 House of Delegates adopted a resolution on alcohol-related motor vehicle accidents which called on the Highway Safety Committee to expand the Norfolk Intoxicated Driver Study to all Level 1 Trauma Centers within the Commonwealth. The Governor received a copy of the resolution, and the Committee has contacted the Attorney General, Mary Sue Terry, to solicit her support of the resolution and to see what steps may be taken for its implementation.

The Committee also studied a report released by the Virginia Transportation Research Council titled *Issues Concerning the Adoption of an Administrative Per Se Statute by the Commonwealth of Virginia*, which studied an administrative system to deal with driving-under-the-influence (DUI) offenses. The Committee will follow the report as it is studied by the Virginia Department of Transportation.

The House of Delegates also referred to the Committee a resolution on health insurance for motorcyclists. Discussion centered on the fact that the argument could be made that all people who engage in high-risk activities should be required to have health insurance. The Committee felt that Society support of a legislative measure calling for motorcycle operator insurance would appear self-serving and send the wrong message to the legislature and the public.

The Committee has reviewed HJR419, which is a study of pedestrian safety laws, and will follow the progress of the study and work with the Legislative Committee to evaluate its findings and determine possible support of its recommendations.

The Committee also discussed the issue of the 55 vs 65 mph speed limit on interstate highways. Although early indications are that fatalities are increasing faster in states with 65 mph speed limits, the available data is still limited. The Committee will also look into the impact of the higher speed limit on school bus safety and is in the process of obtaining information on the Northern Virginia Collision Study.

The Committee continues to work with the Virginia Department of Education on the issue of physical exam standards for bus drivers. The Committee wants the standards published on the exam form, so that the physician can review them, as with exam forms for truck drivers.

Carol S. Shapiro MD

Indigent Care

The primary objective of the Indigent Care Committee is to establish a dialogue with, and to provide useful information to, those state agencies and legislative committees currently dealing with indigent care issues. Two areas of particular concern in this regard are primary care shortages and obstetrical access problems in certain areas of the state.

FINANCE COMMITTEE

Works with the Executive Vice President in developing an annual financial report and in projecting a budget.

Michael A. Puzak, MD, Arlington, Chairman
William H. Barney, MD, Lynchburg
William S. Burton, MD, Nassawadox
Charles M. Caravati, Jr., MD, Richmond
J. Thomas Hulvey, MD, Abingdon
C. Barrie Cook, MD, Fairfax, Adviser
George M. Nipe, MD, Harrisonburg, Adviser
Glenn B. Updike, Jr., MD, Adviser

GRIEVANCE COMMITTEE

Reviews cases concerned with problems between physicians and patients on appeal from decisions of grievance committees of component societies.

C. Barrie Cook, MD, Falls Church, Chairman
Charles M. Caravati, Jr., MD, Richmond
Richard L. Fields, MD, Fairfax
Harry C. Kuykendall, MD, Alexandria
Glenn B. Updike, Jr., MD, Danville

HIGHWAY SAFETY COMMITTEE

Is concerned with all facets of highway safety, especially relating to legislation, and advises the State Legislative Committee accordingly.

Carol S. Shapiro, MD, Woodbridge, Chairman
James C. Andrews, MD, Charlottesville
Richard C. Cole, MD, Stuart
R. Jack Eastham III, MD, Charlottesville
James L. Gardner, MD, Abingdon
Robert J. Heilen, MD, Falls Church
Harry S. Holcomb III, MD, Franktown
William A. Robertson, MD, Richmond

INDIGENT CARE COMMITTEE

Explores problems relating to uninsured citizens. Works with appropriate government agencies.

H. George White, Jr., MD, Winchester, Chairman
C. M. G. Buttery, MD, Richmond, Ex-Officio
John A. Ball III, MD, Arlington
Charles H. Crowder, Jr., MD, South Hill
George M. Nipe, MD, Harrisonburg
Michael J. Petrizzi, MD, Mechanicsville
David J. Reese, MD, Arlington

INJURED INFANTS ACT TASK FORCE

Charged with the responsibility of studying the Act and making recommendations toward achievement of the Act's purpose.

James L. Ghaphery, MD, Richmond, Chairman
John J. Bagley, MD, Richmond
Barbara Brown, PhD, Richmond
Stephen Conley, Richmond
Ronald K. Davis, MD, Richmond
Fritz E. Dreifuss, MD, Charlottesville
James E. Etheridge, Jr., MD, Norfolk
Edward E. Gahres, MD, Alexandria
Danielle Huntington, MD, Falls Church
Edward R. Isaacs, MD, Richmond
Willette L. LeHew, MD, Norfolk
Roger W. Litwiller, MD, Roanoke
Vito A. Perriello, MD, Charlottesville
Robert E. Petres, MD, Richmond
James M. Schwayder, MD, Newport News
Joseph R. Swedish, Fredericksburg
Donald A. Taylor, MD, Richmond
Paul B. Underwood, Jr., MD, Charlottesville
Glenn B. Updike, Jr., MD, Danville
F. Douglas Wall, Richmond
Michelle Whitehurst-Cook, MD, Highland Springs

LONG RANGE PLANNING COMMITTEE

Reviews the mission of The Medical Society of Virginia and makes recommendations concerning new projects and procedures.

C. Barrie Cook, MD, Falls Church, Chairman
Charles M. Caravati, Jr., MD, Richmond
Richard L. Fields, MD, Fairfax
Harry C. Kuykendall, MD, Alexandria
Glenn B. Updike, Jr., MD, Danville

In an effort to facilitate dialogue with agency officials regarding these issues, the Committee arranged a meeting between the President of the Medical Society of Virginia, the chairman of the Indigent Care Committee, and the heads, or their designees, of the four specialty areas most directly affected (obstetrics, family practice, internal medicine and pediatrics) and the Secretary of Health and Human Services, the Hon. Eva S. Teig. The Commissioner of Health, Dr. C.M.G. Buttery, was also present at this meeting and has served as an ex officio member of the Committee. A followup meeting with Secretary Teig is scheduled.

In an effort to develop useful information for agency officials and legislators dealing with indigent care problems, the Society is currently developing a comprehensive questionnaire to be sent to physicians representative of the four specialties named above. The results of this survey will be presented in November to a legislative committee studying problems related to access to health care for the indigent and Medicaid populations. Through its efforts, the Indigent Care Committee is hopeful that the General Assembly will agree to fund pilot projects targeting medically underserved areas, which incorporate some of the responses obtained through the primary and obstetrical care survey.

George H. White, Jr., MD

Injured Infants Act

Members of this Task Force, appointed by the Society's President to study Virginia's Birth-Related Neurological Injury Compensation Act (1987), consist of representatives of the following specialities: obstetrics, neurology, neonatology, anesthesiology, pediatrics, pediatric neurology and family practice. They are accompanied by representatives of the insurance industry and the Virginia Hospital Association and two members at large. It was the feeling of these members that before any meaningful recommendations could be made, additional information was necessary. Specifically, the Task Force wished to determine: 1) the number of infants who could qualify for benefits under the definition of the Act; 2) the number of infants who would qualify for benefits if the definitions were broadened; and 3) the cost of the program as enacted compared to the overall cost of birth-related injuries under the tort system.

Since this information required a study and since the task force had no funding, it was fortunate that we were able to interest the Williamson Institute for Health studies at Virginia Commonwealth of University in this project. Barbara Brown, PhD, of the Institute prepared an application for a study grant of $195,000 from the Robert Wood Johnson Foundation. If the grant had been approved, the money would not have been available for eleven months. The task force not wishing to wait that long, commissioned Dr. Brown to conduct a pilot study of infants born at MCV. The cost of the pilot study was $10,000, which was raised by Dr. Ronald K. Davis, who received $5,000 contributions, from both the Virginia Insurance Reciprocal and the Medical Protective Company. St. Paul was asked to participate but declined. The pilot study has been completed; the results were published in the March 1989 issue of Virignia Medical.

The Robert Wood Johnson grant was denied. The Task Force, wishing to continue its study, commissioned Dr. Brown to make a determination of birth-related injuries most likely to result in litigation by reviewing claims by medical malpractice insurance carriers in Virginia. The cost of the second study was $8,500, of which $5,000 was raised by Dr. L. Daniel Crooks, Jr., and the obstetrical community and $3,500 was approved by the Council of The Medical Society of Virginia. The re-

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INSURANCE COMMITTEE

Recommends new insurance programs and reviews those already in effect, with particular attention to liability coverage.

Ira D. Godwin, MD, Fairfax, Chairman
Lawrence E. Blanchard III, MD, Richmond
Owen W. Brodie, MD, Richmond
William S. Burton, MD, Nassawadox
John L. Dobson, MD, Virginia Beach
J. William Giesen, MD, Radford
David A. Vaughan, MD, Lynchburg

JOINT PRACTICE COMMITTEE

Meets with representatives of nursing and hospitals to review and recommend proposals involving the health professions.

John A. Owen, Jr., MD, Charlottesville, Chairman
Lucia Pastore, MD, Falls Church
William W. Regan, MD, Richmond
Charles H. Townes, MD, Colonial Heights

MATERNAL HEALTH COMMITTEE

Is concerned with all facets of maternal health. Studies maternal deaths in Virginia and makes recommendations. Keeps abreast of the insurance aspects of maternal health.

John R. Talbert, MD, Waynesboro, Chairman
Mason C. Andrews, MD, Norfolk
Thomas P. Caine, Jr., MD, Newport News
Charles Y. Davis, MD, Blacksburg
Guy M. Harbert, Jr., MD, Charlottesville
Herbert G. Hopwood, MD, Arlington
Robert W. Irvin, Jr., MD, Roanoke
David L. Montague, MD, Richmond
Louis Q. Pugsley, MD, Fairfax
Faye O. Redwine, MD, Richmond

sult of the second study is to be completed shortly and will then be distributed.

The 1989 General Assembly established a joint legislative subcommittee, chaired by Del. Chip Woodrum of Roanoke, to study the definition and funding provisions of the Injured Infant Act. The information generated through the efforts of the Task Force is expected to be of benefit to this subcommittee, which will then determine if legislative change is necessary or desirable.

James L. Ghaphery, MD

Insurance

During this past year the Committee reviewed a number of ongoing programs that it has endorsed in the past. Currently we are studying the Society-endorsed disability plan. We are considering adding a non-cancellable, individual policy which has many attractive features.

Two possibilities for endorsement in the future are long-term care and retirement plans. The Committee has been following long-term care for the past two years and does not anticipate an endorsement in the very near future.

This year we have spent more time studying retirement plans than any other single item. A survey is being made to determine if there is an interest in a Society-endorsed retirement plan; we expect to have results of the survey before the annual meeting.

The major Society-endorsed program continues to be the health insurance plan with Virginia Blue Cross and Blue Shield. This is an experience-based plan, and our rates for 1990 will be based on plan-utilization over a 12-month period beginning in mid-1988.

Dr. William S. Burton resigned from the Committee in mid-year. Bill has been a great help to me and has provided tremendous input into the Committee. He will be greatly missed.

Ira D. Godwin, MD

Joint Practice

Following an initial meeting for informational purposes, this committee has established a network for sharing new developments regarding the nursing shortage and related issues. As a result, the Medical Society of Virginia is presenting a panel discussion on this topic on November 11, as part of the annual meeting. The Committee will continue these activities, and wishes to explore possible coordinated approaches to the legislature on this issue, where such action would be appropriate.

John A. Owen, Jr., MD

Maternal Health

Recommendation

That all health providers, especially emergency room personnel and practicing physicians, be ever aware of ectopic pregnancy as a cause of death among young women almost every year in Virginia.

General

At a meeting of the Maternal Health Committee on July 12, 1989, a review of the 14 maternal deaths occurring in Virginia in 1988 was given by Dr. Faye O. Redwine. Four patients died of pulmonary embolism. Two deaths resulted from complications of pregnancy induced hypertension. Two patients died of exsanguination. One of these was from a large retroperitoneal hematoma following a cesarean section, and the other was due to a ruptured ectopic pregnancy. This patient died in the hospital some five hours after entering the emergency room. The cause of death in the remaining six patients was not accurately determined due to either the lack of an autopsy or unavailability of records.

The activities of the State Perinatal Advisory Board as reported by Dr. Guy M. Harbert, Jr., were directed largely toward improvement

in availability of maternal, prenatal maternal, neonatal transport to appropriate centers of care. Another major effort is to develop minimum requirements for licensure of units providing maternity care and newborn care, based on levels of care provided.

Sandra L. Kramer, counsel for the Medical Society of Virginia, reported that St. Paul has authorized a 10.3% liability insurance premium decrease. She also reported that participation in the Injured Infants Act remains good among physicians and hospitals and that the General Assembly has approved a 25% increase in Medicaid rates during the next three years.

The infant mortality rate in Virginia in 1987 was 10.1/1000 live births, the lowest ever. The national rate was 10/1000 live births. Virginia now ranks 27th among all states, as reported by Dr. Alice Linyear, director of Maternal-Child Health. She also reported great concern over the apparent decrease in access to obstetrical care among indigent prenatal patients. More counties each year report no provisions for caring for this population. Studies are now ongoing to seek methods to correct this deficiency.

The Committee indicated a strong desire that representatives of the various obstetrical/gynecological societies in the state be allowed input into the Board of Health Professions' public hearings on the role of the nurse practitioner.

The Maternal Health Committee considers its primary responsibility to be the review of all maternal deaths in Virginia, but it is interested in all matters pertaining to the delivery of quality obstetrical care.

John R. Talbert, MD

MEMBERSHIP COMMITTEE

Works with MSV staff on problem situations and recruitment. Responsible for recommending members for honorary status.

James L. Patterson, Jr., MD, Pulaski, Chairman
Gordon L. Avery, MD, Arlington
Charles H. Crowder, Jr., MD, South Hill
Palmer W. Fant, MD, Independence
James E. Nevin, MD, Danville
Louis D. Parham, Jr., MD, Hampton
Norris A. Royston, MD, Marshall
Clarke Russ, MD, Virginia Beach
Carol S. Shapiro, MD, Woodbridge
James A. Shield, Jr., MD, Richmond
Kenneth D. Tuck, MD, Roanoke
J. Bradley Terry, Richmond, Student

Membership

Recommendations

1. Continue current Medical Society of Virginia staff efforts and activities in membership recruitment.

2. Continue current Medical Society of Virginia leadership outreach program with personal contact activities in membership.

3. Develop a total market program for the Medical Society of Virginia by competent marketing experts, employed by the Society, with funds appropriated by Council.

4. Confer honorary active membership on J. Thomas Hulvey, MD, President of the Medical Society of Virginia.

General

Membership in the Medical Society of Virginia continues to be a problem in 1989. According to the annual report from our staff, total membership has dropped from 6,003 to 5,880 as of July 31, 1989. The numbers indicate that those who were dropped from membership for failure to pay dues the year before, those who resigned for different reasons and those who have not paid dues for 1989 have increased again. New member numbers are also below 1988.

A review of activities by the membership committee over the past three years indicates almost all avenues of recruitment have been tried with poor results. Enumerating the reasons given for not belonging to our Society will not be repeated. Survey results noted in the report given to the Council indicated a general dissatisfaction of many members with organized medicine, including both the American Medical Association and the Medical Society of Virginia.

Personal comments made on the recent survey answer sheets were strongly negative, indicating our failure to effectively reduce the problems our profession faces in dealing with government and insurance agencies. We feel this is due largely to lack of information provided to physicians of the continuing efforts of Society members working with these agencies. Many accomplishments are there, but our failure to communicate this to our colleagues is one reason they feel we are impotent in our relationships with these agencies. Therefore, we must employ marketing experts to help us. Council has agreed to this and has appropriated funds to do so.

However, before this will succeed, the Medical Society of Virginia, through its House of Delegates, must address the issue of continuing MSV/AMA unification or deunifying. This recommendation appears in the report of the Unification/Deunification Committee.

In addition to all activities noted in reports of previous membership committees the person-to-person program through our leadership was not enough to increase our membership significantly this year. This program was formulated and presented to us by the American Medical Association at no small expense, and may still result in at least some increase in our membership. These efforts will be continued, as will the efforts of our staff on Dover Road to recruit new members and bring back those who have not renewed membership. We must give the staff and a marketing expert a positive presentation for their activities.

J. L. Patterson, Jr., MD

MENTAL HEALTH COMMITTEE

Works with the Department of Mental Health and Mental Retardation and reviews and recommends legislation having to do with mental health.

James A. Shield, Jr., MD, Richmond, Chairman
Douglas H. Chessen, MD, Newport News
Robert D. Gardner, MD, Lynchburg
William L. Harp, MD, Richmond
John F. Heath, MD, Falls Church
Emory F. Hodges, Jr., MD, Alexandria
John O. Hurt, Jr., MD, Salem
Asad M. Masri, MD, Petersburg
Tim Kane, Charlottesville, Student

MSVRO OVERSIGHT COMMITTEE

Acts as the physician's advocate in overseeing the Medical Society of Virginia Review Organization.

William H. Sipe, MD, Newport News, Chairman
Theodore Adler, MD, Virginia Beach
Wyatt S. Beazley III, MD, Richmond
William J. Hagood, Jr., MD, Clover
George A. Hurt, MD, Lynchburg
Esmail Rafi, MD, Fairfax
Norris A. Royston, MD, Marshall
Ray H. Smith, MD, Richmond
E. Armistead Talman, MD, Richmond

Mental Health

The review of patterns of practice in Virginia's psychiatric hospitals undertaken by the General Assembly is being addressed by the Medical Society of Virginia and the Psychiatric Society of Viginia.

A study of mandated health benefits, including mandated mental health benefits, especially for inpatient care is also a subject before the General Assembly. It is the opinion of the Mental Health Committee that the average patient in Virginia often has no direct access to any buying decision with regard to health insurance. These decisions are often made by corporate management and there is not truly an opportunity for citizens to make an educated decision about mental health insurance or the company from which it is purchased. The reasoning and logic behind the initial mandate for nervous and mental coverage is still valid and there should be no change in the requirement that mental health benefits should be included for both inpatient and outpatient care and no change in the requirement that mental health benefits, especially for mental health care, remain mandated.

With regard to training of psychiatrists, it is the feeling of the Mental Health Committee that the Virginia Department of Mental Health and Mental Retardation should consider stipends in support of resident training in adult and child psychiatry at the medical schools in the Commonwealth of Virginia with the understanding that time would be spent in public mental hospitals, mental health clinics, and/or other state facilities following the completion of training. There continues to be a shortage of psychiatric services in public mental health clinics.

A review is being conducted by the Commonwealth of Virginia on the priorities for public spending in provision of mental health services. The Committee reviewed the demands for service for drug addicts and alcoholics and the difficulties of meeting the needs. It was felt that the Medical Society of Virginia in collaboration with the Psychiatric Society of Virginia are addressing the issues presently for us.

James A. Shield, Jr., MD

MSVRO Oversight

As requested by the Medical Society of Virginia's House of Delegates at its 1988 annual meeting, the Board of the Medical Society of Virginia Review Organization adopted on December 21, 1988, the following three procedures:

1. In Severity I Level cases two physicians of the specialty in question and of the same type of practice will review the case where there is a question of a quality problem.
2. In Potential Severity II and III Level cases two physicians of the specialty in question and of the same type of practice will have unanimous agreement prior to referral to the Regional Review Committee.
3. The Quality Assurance Committee will include three ad hoc members of the same specialty and type of practice as the physician or provider under investigation.

A letter was sent to all members of the Medical Society of Virginia pertaining to the adopted procedures requesting their cooperation and participation in the peer review process.

There was concern regarding the quality denial provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Section 9403. In response to a request by the Oversight Committee, Council unanimously adopted a resolution pertaining to the quality of care denial letter for submission to the June meeting of the AMA House of Delegates. If the current law cannot be changed, the Oversight Committee unanimously agreed that the denial of payment for substandard care must be consistent and adhere to the current due-process procedures as established by the MSVRO.

During the year complaints were minimal due to an improved sanctioning system and review competency. Members of the Oversight Committee have been receiving minutes of the Medical Society of Virginia Review Organization board meetings and invitations to their bimonthly meetings.

There are no current recommendations.

William H. Sipe, MD

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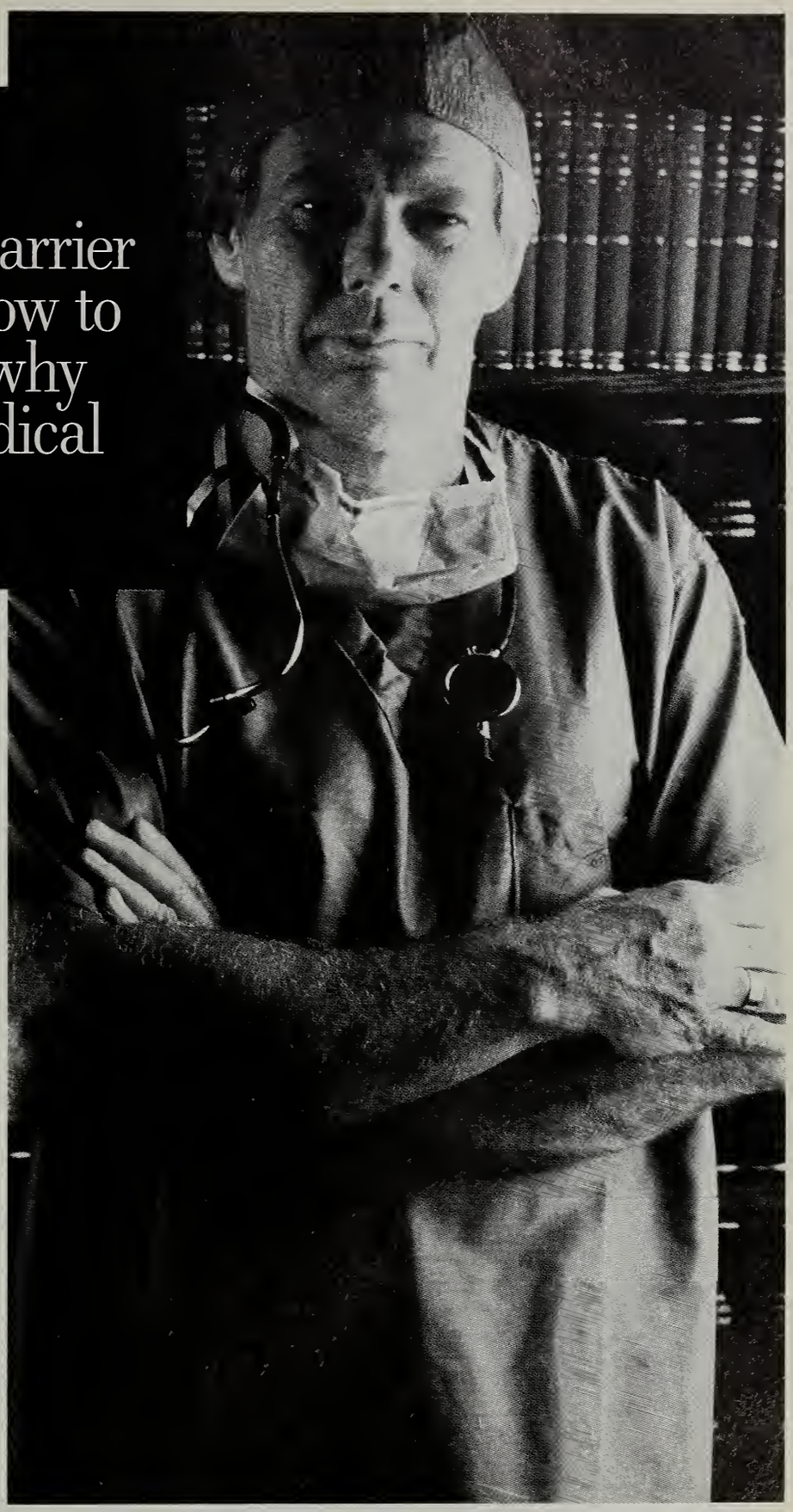

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PHYSICIANS' HEALTH AND EFFECTIVENESS COMMITTEE

Assists in the discovery and rehabilitation of those physicians whose effectiveness in the practice of medicine is jeopardized by continuing problems.

David G. Fluharty, MD, Newport News, Medical Director
William P. Arnold III, MD, Charlottesville, Cochairman
Carol S. Shapiro, MD, Woodbridge, Cochairman
Owen W. Brodie, MD, Richmond
Robert M. Campbell, MD, Chesapeake
Milton Greenberg, MD, Danville
Mrs. Karen Harp, Richmond
David S. Harrer, MD, Falls Church
Mark E. Holt, Jr., MD, Portsmouth
Lawrence K. Monahan, MD, Roanoke
Lloyd F. Moss, MD, Fredericksburg
John A. Owen, Jr., MD, Charlottesville
Mrs. William J. Reardon, McLean
Basil E. Roebuck, MD, Blacksburg
Jeremy A. Stowell, MD, Portsmouth
J. Pat Tokarz, MD, Alexandria
William H. Barney, MD, Lynchburg, Adviser
Mrs. Carolyn Moore, Norfolk, Adviser
A. Michael Deep, Richmond, Student

PROGRAM COMMITTEE

Develops the scientific program for the annual meeting.

Leslie E. Rudolf, MD, Charlottesville, Chairman
James P. Baker, MD, Norfolk
W. Kenneth Blaylock, MD, Richmond
George W. Burke III, MD, Richmond
C. M. Kinloch Nelson, MD, Richmond
James A. Piggott, MD, Lynchburg
Paul Mazmanian, PhD, Richmond, Adviser

Physicians' Health and Effectiveness

Recommendation

It is recommended that the annual budget for the Physicians' Health and Effectiveness Committee for 1990 be $18,000. The sum is based on the budget approved by the Committee.

General

The Physicians' Health and Effectiveness Comittee has been involved comprehensively in both educational and operational aspects of physician impairment. Through arduous work and frequent travelling required by her job, the Committee's executive director, Mrs. Jeanne Douglas, has added substantially to the Committee's significant contributions to both the Medical Society of Virginia and to the physicians of the Commonwealth. What follows is a summary of the highlights of the Committee's work over the past year.

Operational. In 1988, 33 individuals were reported to the Committee. Twenty-six were intervened upon. Investigation of seven led to no evidence impairment. The number of physicians currently being followed is 52. Many others have now completed their contracts with us. The total number of physicians reported to the Committee represents another significant increase over the previous year, which we feel is due to increasing physician awareness of the supporting role the Committee takes in the delivery of aid to impaired physicians.

The program's protocols have been revised to take into account the functions served by the medical director. Other changes, based primarily on the experience of the Committee, have also been incorporated. For example, protocols have been established to modify monitoring procedures in the event of relapse. A manual of the Committee's policies, procedures, and protocols is being published for use by members, monitors and intervenors and investigators. This important work is being edited by Lawrence K. Monahan, MD.

The loan fund, designed to meet the treatment needs of Virginia physicians not able to pay for their own care, has been financially supported by the Medical Society of Virginia and is now in place. Lloyd F. Moss, MD, is chairman.

A committee to evaluate Virginia state treatment centers as potential referral sites for the treatment of impaired physicians has collated the data and in essence graded treatment centers based on the treatment needs established by the Committee. This important subcommittee was chaired by Dr. William P. Arnold III, MD.

Educational. The annual educational meeting of the Physicians' Health and Effectiveness Committee chaired in 1988 by William P. Arnold III, MD, was held in Williamsburg in December and attended by nearly three times (128) the number of attendees of the prior year. Among the prestigious speakers were former Congressman Wilbur Mills; Dr. Donald Ian MacDonald, presidential advisor on chemical dependency to President Ronald Reagan; Dr. G. Douglas Talbott; Dr. William J. Farley; and many other well known individuals. During the annual meeting, Lorraine McGehee, prior executive director, was recognized for her outstanding efforts in behalf of the Committee.

The Committee has been represented by its medical director and executive director in regional workshops sponsored by the American Medical Association to facilitate cooperative efforts with other state societies. The Committee has also been represented from the platform by its medical director at national meetings held in Atlanta, Denver, Washington and Anchorage, Alaska. Additionally, an intervention workshop was held for the Alaska Medical Association Impaired Physicians' Committee by Dr. Fluharty and Mrs. Douglas.

Several other important educational ventures are currently in pro-

gress. The Committee has supported an effort undertaken by the medical auxiliary to establish a Medical Family Care and Educational Program for medical families in crisis. This innovative program is chaired by Karen Harp. Cooperative ventures have been established with impaired physicians committees representing hospitals throughout the state who have sought support from the Committee. Finally, the Committee is in the process of contracting with the psychologists in the state to provide administrative services analogous to those now existent in behalf of the Medical Society of Virginia.

The Committee continues to serve the members of the Medical Society of Virginia, other physicians in the Commonwealth and also the public at large through both its educational projects and its operational functions.

William P. Arnold III, MD
Carol S. Shapiro, MD

Professional Liability

For the first time in many years, the Professional Liability Committee has no bad news to report. A dramatic reduction in frequency of claims has reduced insurance costs and, for the most part, rates are being reduced across the country, including Virginia. Many explanations have been offered including: the effects of tort reform of the past several years, threat of losing the cap, increased interest income by insurance industry, and the ethereal, cyclic, nature of the malpractice problem. Even if the answers aren't clear, physicians can enjoy a respite from this blight on the otherwise enjoyable practice of medicine. The Professional Liability Committee will continue to meet as needed to monitor the legislative changes already achieved and plan additional initiatives as indicated and politically possible. Studies are still being conducted and pressure applied to relieve the medical community of the assessment under the Injured Infant Act. Efforts to improve this act are reported by the Injured Infants Task Force Committee.

Ronald K. Davis, MD

Public Relations

Recommendation

That the Committee be renamed the Public Relations and Communications Committee.

General

Numerous projects have been conducted by The Medical Society of Virginia under the auspices of the Public Relations Department. The society has developed two newsletter formats to replace the quarterly MSVNews. *Pulse* is a monthly publication sent to hospital medical staff, component and specialty societies and contains information on Society activities relating to legislation, regulation, and other policy matters of interest to Virginia physicians. *Med-Alert* is distributed to all members of the Society when urgent communication is necessary.

The Committee also asked the Society to develop a retirement folder for its members. The folder, entitled *Closing Your Practice,* was made available to Virginia Physicians in June 1989.

A revised version of the Natural Death Act was made available to physicians and clergy in the Commonwealth. Efforts are to be made to include the Virginia Chapter of the American Association of Retired People in the further distribution of this living will.

The Committee continues to strengthen relations with the media and is planning a press room at the 1989 Annual Meeting of the Medical Society of Virginia.

A teen health project is currently being conducted by the Medical Society of Virginia Auxiliary The Committee has pledged its support for the project and offered its assistance in publicizing the event.

Jeffrey W. Wilson, MD

PROFESSIONAL LIABILITY COMMITTEE

Keeps abreast of professional liability issues, especially as they relate to tort reform. Communicates with legislators and subcommittees of the state legislature.

Ronald K. Davis, MD, Richmond, Chairman
Robert L. Adeson, MD, Alexandria
Alvin E. Conner, MD, Manassas
L. Daniel Crooks, Jr., MD, Midlothian
Emerson D. Farley, Jr., MD, Richmond
John E. Fitzgerald, MD, Richmond
James L. Ghaphery, MD, Richmond
William H. Grover, MD, Lowry
Austin B. Harrelson, MD, Richmond
George A. Hurt, MD, Lynchburg
Russell L. May, MD, Annandale
David L. Montague, MD, Richmond
James D. Mumper, MD, Richmond
C. M. Kinloch Nelson, MD, Richmond
Claude P. Sherman, MD, Martinsville
Kenneth D. Tuck, MD, Roanoke
Glenn B. Updike, Jr., MD, Danville
H. George White, Jr., MD, Winchester
Harold L. Williams, MD, Newport News
Victor M. Brugh, MD, Richmond, Adviser
Samuel B. Hunter, MD, Richmond, Adviser
Tom Lallas, Charlottesville, Student

PUBLIC RELATIONS COMMITTEE

Is responsible for all Medical Society of Virginia projects in the field of public relations.

Jeffrey W. Wilson, MD, Lynchburg, Chairman
S. D. Barranco, MD, Blacksburg
John Boniface, Jr., MD, Fredericksburg
George E. Broman, MD, Culpeper
Raymond S. Brown, MD, Gloucester
J. Paul Bullock, Jr., MD, Richmond
Norman R. Edwards, MD, Newport News
William A. Hazel, Jr., MD, Herndon
Steven B. Leichter, MD, Norfolk
Norris A. Royston, MD, Marshall
Mrs. Lewis Curd, Wiliamsburg, Adviser
Mrs. Donald G. Seitz, Richmond, Adviser
Mrs. Philip Thomason, Portsmouth, Adviser

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Rehabilitation

Throughout the year, the Rehabilitation Committee, both individually and collectively, continued its primary role of providing advice and recommendations to the Virginia Department of Rehabilitative Services in regard to policies, procedures and appropriate fees for medical services provided by the Department to disabled citizens of the state.

The Committee met on May 21, 1989, with 13 members present. Also present were six members of the staff of the Department.

Altamont Dickerson, Jr., EdD, Commissioner of the Department, gave an overview of the activities and accomplishments of the Department during the past year and the special challenges that face the Department now and in the future. The Committee reviewed and approved a proposed complete reorganization and revision of the Diagnostic and Miscellaneous Medical Services Schedule. It recommended that the Department not reimburse directly to physician assistants a separate or additional fee for assistance provided during operations. The Committee considered the problem of prophylactic procedures such as surgery for cervical dysplasia. While recognizing that such surgical procedures were well accepted and proper medical practice, such are not appropriate for Department funding since the conditions are not actually disabling currently and the procedures proposed are essentially prophylactic. Other matters considered by the Committee were the reimbursement policy for laser surgery and the appropriateness of exploratory surgical procedures. It was the Committee's opinion that these were a matter of individual consideration. The Committee recommended disapproval of dental implants and a proposed grant for a "Revitalization Center" project.

The Committee has no recommendation for presentation to the House of Delegates.

Alexander McCausland, MD

REHABILITATION COMMITTEE

Serves in an advisory capacity to the State Department of Rehabilitative Services.

Alexander McCausland, MD, Roanoke, Chairman
Thomas C. Apostle, MD, Winchester
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Ronald F. Calkins, MD, Richmond
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Leroy Smith, MD, Richmond
Frank A. Strickler, MD, Roanoke
Nelson S. Teague, MD, Roanoke
Girard V. Thompson, Jr., MD, Chatham
Roger Winborne, Jr., MD

Rural Health

Recommendation

That The Medical Society of Virginia adopt the following statements as a portion of its position and policy on rural health matters in Virginia and the nation:

1. Equal federal reimbursement for health care services; not the present 40% rural detriment versus urban.

2. Increase the Virginia medical rural scholarships to $10,000 or more and REQUIRE the underserved area practice agreement.

3. Promote tort reform, control of litigation costs and awards.

4. Advocate a new malpractice adjudication system similar to Workers Compensation in Virginia.

5. Soften the federal harassment of physicians under "antitrust", adverse data bank, peer review, etc.

6. Support the physician and his family who is being sued by professional coverage, organization advice, moral support, expert testimony, etc.

7. Encourage the establishment of community credit sources or an endorsement authority for a physician's new practice expenses.

8. Support the expansion and responsibilities of the primary care departments and services at the three medical schools with scheduled rural health participation periods for ALL students.

9. Encourage the medical schools to accept more students who are qualified and who apply from rural areas. Review admissions committee membership.

10. Advocate increased Medicaid reimbursement levels which often is a major part of practice in an underserved area.

11. Support the Harvard resource-based relative value scale, in principle, for more realistic reimbursement of services rendered.

12. Suggest methods for quicker recovery of equipment and technology costs in rural or indigent areas where volume of usage is not as great.

13. Protect the concept of solo practice in primary care against insurance prejudice, quality care screening procedures of too high expectancy, etc.

14. Informed support for the medical transport system, particularly in underserved areas.

General

The members of this Committee representing all areas of the Com-

RURAL HEALTH COMMITTEE

Is concerned with all facets of rural health. Cooperates with the Virginia 4-H Club health awards program.

Charles H. Crowder, Jr., MD, South Hill, Chairman
Francis N. Bain, MD, Goochland
Emerson D. Baugh, Jr., MD, Kenbridge
Lewis W. Bridgforth, MD, Victoria
Gene E. Clapsaddle, MD, Moneta
Joseph H. Early, Jr., MD, Hillsville
John T. Glick, Jr., MD, Broadway
Augustine W. Lewis, MD, Aylett
Norris A. Royston, MD, Marshall
Robert S. Smith, MD, Richmond
Girard V. Thompson, Jr., MD, Chatham

SCHOLARSHIP COMMITTEE

Cooperates with Virginia's three medical schools in the administration of Medical Society of Virginia scholarship funds.

James W. Craig, MD, Charlottesville, Chairman
B. Lewis Barnett, Jr., MD, Charlottesville
Robert F. Baxter, MD, Grundy
Peter G. Bernad, MD, Alexandria
John L. Dodson, MD, Virginia Beach
Fitzhugh Mayo, MD, Richmond
John A. Owen, Jr., MD, Charlottesville

SPORTS MEDICINE COMMITTEE

Works with coaches, trainers and team physicians to upgrade sports medicine in the state. Maintains liaison with high schools, colleges and the Virginia High School League. Presents seminars.

Frank C. McCue III, MD, Charlottesville, Chairman
S. D. Barranco, MD, Blacksburg
Charles H. Bonner, MD, Richmond
Ernest L. Clements, Jr., MD, Richmond
Richard H. Fisher, MD, Salem
Richard W. Graham, MD, Richmond
Jay E. Hopkins, MD, Lynchburg
J. Thomas Hulvey, MD, Abingdon
Virgil R. May, Jr., MD, Richmond
Louis P. Ripley, MD, Roanoke
Robert P. Singer, MD, Richmond
Robert W. Sydnor, MD, Lynchburg
David N. Tornberg, MD, Newport News
Brantley P. Vitek, MD, Annandale
Earl D. White II, MD, Hampton
David B. Young, MD, Norfolk

monwealth have worked individually and collectively to accumulate, review and interpret volumes of data from many sources. In addition, the recommendations above have been constructively reviewed by many concerned individuals, entities, and agencies—local, state, and federal. Coordination has been maintained with the MSV Indigent Care Committee.

As usual, a Committee member represented the Medical Society of Virginia at the annual 4-H Club convention in Blacksburg, and the award was presented for the best medical project to the state winner.

Charles H. Crowder, Jr., MD

Sports Medicine

The Sports Medicine Committee was active in the 1989 General Assembly in the passage of HB 1649, a bill granting civil immunity for volunteer team physicians in the Commonwealth. "Good Samaritan" status was given to those physicians who provide emergency medical care as volunteer team physicians.

Members of the Sports Medicine Committee continue to advocate the many benefits of having board-certified trainers in the Virginia school system. The Committee reaffirmed its support for this measure and suggested that the Virginia Athletic Trainers Association solicit endorsements from the Virginia High School League and the Parent Teachers Association for further backing of this proposal.

The Committee was asked to review the new high school physical examination form being distributed by the Virginia High School League (VHSL). Members were apprised that many Society members had expressed concern over the new format as recently adopted by the VHSL. It was the general feeling of the Committee that the form included many procedures that should be considered optional and performed only at the discretion of the physician. The Tanner Stage test or maturation index, to measure body fat percentage and the hemoglobin check were all cited as time-consuming and unnecessary in most cases. The group agreed that the logistics of trying to perform every test indicated on the form would be a great deterrent to most physicians providing a physical exam.

A recommendation was made that the committee review this new form for further modification allowing for more physician discretion with regard to certain testing requirements. The Committee agreed to this recommendation and offered that these tests could be repositioned on the form with an "optional as indicated" designation. A second motion was made that a joint meeting be held between the Society's and the VHSL's Sports Medicine Committees to discuss the possibility of revising the current form. Members agreed to the motion and planned on a meeting with members of the VHSL in the fall.

The Committee plans to observe closely the state legislature's task force studying the use of anabolic steroids. Members were advised of the progress of this committee and informed that their assistance may be needed in the near future.

Frank C. McCue, MD

State Bar Liaison

A joint meeting of the Medical Society of Virginia and the Virginia State Bar Liaison Committees was held on May 25, 1989, at the Hyatt Hotel in Richmond.

The committees reviewed the "safe harbor regulations" that are being promulgated by the Department of Health and Human Services. These regulations will define

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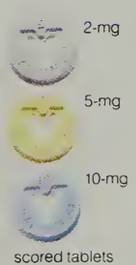

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STATE BAR LIAISON COMMITTEE

Works with the State Bar Committee to resolve problems of mutual interest and concern.

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M. Mendel Bocknek, MD, Annandale
George M. Nipe, MD, Harrisonburg
Claude P. Sherman, MD, Martinsville
Charles H. Townes, MD, Colonial Heights
David K. Wiecking, MD, Richmond

STATE LEGISLATIVE COMMITTEE

Considers all pending legislation and makes recommendations concerning Society support or opposition. Prepares legislation for introduction at the General Assembly.

Kenneth D. Tuck, MD, Richmond, Chairman
Sam Barton, MD, Richmond
H. Alan Bigley, Jr., MD, Petersburg
Robert M. Blizzard, MD, Charlottesville
Leon I. Block, MD, Falls Church
Bruce M. Bucher, MD, Tappahannock
William W. S. Butler III, MD, Roanoke
John M. Daniel III, MD, Richmond
Russell D. Evett, MD, Norfolk
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Lindley T. Smith, MD, Richmond
Oscar Thorup, Jr., MD, Charlottesville
Glenn B. Updike, Jr., MD, Danville
Edgar N. Weaver, Jr., MD, Roanoke
Gerald Weitzman, MD, Portsmouth
Harold L. Williams, MD, Newport News
H. C. Alexander III, MD, Roanoke, Adviser
Ernest L. Clements, Jr., MD, Richmond, Adviser
Clarence A. Holland, MD, Virginia Beach, Adviser
Earl E. Virts, MD, Purcellville, Adviser
Percy Wootton, MD, Richmond, Adviser
Sabrina Bent, Charlottesville, Student

THERAPEUTICS AND DEVICES COMMITTEE

Concerned with matters pertaining to drugs and their relationship to the practice of medicine.

John Boniface, Jr., MD, Fredericksburg, Chairman
George B. Craddock, Jr., MD, Charlottesville
Clyde E. Guthrow, Jr., MD, Lynchburg
Karen L. Hermansen, MD, Fairfax
John W. Knarr, MD, Pulaski
Duncan S. Owen, Jr., MD, Richmond
Stanley C. Tucker, MD, Richmond
William A. Greisner III, Norfolk, Student

the business practices or arrangements that physicians and other healthcare providers may engage in without being considered in violation of the anti-kickback provisions in the Social Security Act. Violations of these provisions are considered felonies, with fines up to $25,000 and imprisonment for up to five years. The concern raised during the discussion was that many business arrangements now in place may not be included in the protected business practices and would then be subject to possible prosecution. It was the consensus of those present that both professions need to follow these developments closely and advise members to be prepared to make any necessary changes in current business practices to comply with the new regulations. It was noted that the cover article in the May issue of VIRGINIA MEDICAL addressed the safe harbor regulations and all are encouraged to read it.

The Committee is also investigating the possibility of encouraging local medical society and bar groups to form local liaison committees to improve intra-professional relationships in their localities. The State Bar Liaison Committee will continue to educate its members and judges on the existence and importance of the *Principles of Cooperation for Physicians and Attorneys* brochure promulgated by the State Bar and the Medical Society of Virginia. The committee is also participating in the malpractice arbitration project sponsored by the Alternative Disputed Resolution Subcommittee of the MSV Professional Liability Committee.

Your Committee continues to work closely with the legal profession to create an atmosphere of cooperation and understanding between physicians and attorneys. The Committee received no significant complaints from members this year.

Ira M. Cantin, MD

State Legislative

The State Legislative Committee met on three occasions immediately before and during the 1989 General Assembly session to evaluate potential or actual legislative proposals and to establish the Medical Society of Virginia's position on significant issues. Going into the 1989 legislative session, there were three pieces of carryover legislation of major concern to medicine. These included a bill revising the standard of care in medical malpractice actions, a bill to limit the use of pound animals for medical research, and the psychiatric nurse reimbursement bill.

The Committee was actively involved in developing an alternative standard of care bill, which includes, for the first time, an active clinical practice requirement, and which clarifies that physicians' professional corporations are under the protection of the medical malpractice cap on damages. In part due to the efforts of dedicated physicians, the pound animal bill was revised so as to maintain the availability of pound animals for research purposes. The psychiatric nurse bill was modified to develop a regulatory mechanism to identify nurses with specialty qualifications eligible for direct reimbursement.

The Society successfully sought passage of bills establishing immunity for team physicians, and establishing a legislative study committee (HJR 297) to reexamine the Injured Infant Act. With regard to the latter, a group of eight legislators will consider modifying the definition of a compensable injury under the act, and also whether any change in the funding mechanism is desirable.

In addition, the Committee considered prospective AIDs legislation in detail and was able to secure some important changes in that legislation. It also had input into several other bills important to medicine. The Committee has the help and support of its recently developed "Key Contact Physician" program and of the

MSV Auxiliary in carrying out its activities during the 1989 session.

Following the 1989 session, the Committee met to evaluate the effectiveness of the Society's legislative effort. Toward this end, it suggested methods of improving communications between the Legislative Committee and various other groups or committees concerned with legislation. These include VaMPAC, the MSV Auxiliary, specialty societies potentially affected by legislative activity, the Key Contact Physicians and various MSV committees directly or indirectly involved in political or legislative activity. It also considered the desirability of developing a revised Legislative Protocol and time table which would enable the Medical Society of Virginia to take positions at an earlier time. This would enhance the ability of the Committee to coordinate effectively the various groups involved in state legislative activity. Finally, the Committee is hopeful that it will be able to conduct seminars for its Key Contact Physicians next year, to maximize their effectiveness in dealing with legislators.

In the interim period between meetings, a subcommittee of the Legislative Committee has been established to deal directly with legislative issues related to allied health professionals. Additionally, the Committee, through the Society's lobbyists, is monitoring several legislative and administrative studies of interest to medicine.

Kenneth D. Tuck, MD

UNIFICATION/DEUNIFICATION COMMITTEE

Addresses problems associated with unification and deunification. Conducts surveys. Reports to Council.

James L. Patterson, Jr., MD, Pulaski, Chairman
H. C. Alexander III, MD, Roanoke
J. Hayden Hollingsworth, MD, Roanoke
William S. Hotchkiss, MD, Virginia Beach
Glenn B. Updike, Jr., MD, Danville

VaMPAC

The political action committee of The Medical Society of Virginia is involved in both state and federal legislative activity.

Barbara A. Mella, MD, Oakton, Chairman
H. Alan Bigley, Jr., MD, Petersburg, Chairman Elect
Clarence A. Holland, MD, Virginia Beach, Vice Chairman
Charles H. Crowder, Jr., MD, South Hill, Treasurer
Read F. McGehee, Jr., MD, Richmond, Secretary

Unification/Deunification

Recommendation

That the Medical Society of Virginia's House of Delegates, at the 1989 annual meeting, reevaluate the 1986 decision making American Medical Association membership requisite to affiliation with the Society.

Because of the decline in MSV membership following adoption of unification and to address other, possibly related problems, a Physicians Opinion Survey was formulated and mailed to all physicians in Virginia early this year. The responses were sent for tabulation to the AMA, and the resulting data presented to a joint meeting of the Unification/Deunification, Executive, and Membership Committees. The AMA analysts reported definite evidence of dissatisfaction with unification among the respondents, but in their view it was not sufficient to warrant a recommendation for deunification. On referral of the results to Council, it was the consensus that neither could reaffirmation of unification be made in light of the survey's responses. The Committee feels, therefore, that the unification action taken by the House of Delegates in 1986 should be reviewed at the coming annual meeting.

J. L. Patterson, Jr., MD

VaMPAC

The health care problems of the Commonwealth of Virginia are many. The solutions to these problems can be realistically found only by a team approach of physicians with their legislators. It is essential that all of us become acquainted with our legislators. VaMPAC has worked with the Medical Society of Virginia lobbyists and the Legislative Committee during the past year to develop this team approach to solutions of our health care problems.

American medicine is travelling rough seas. Every periodical carries some comment about needed changes in our system. Many believe that a national health care system should be established. Very few have addressed the actual cost or the rationing that this would entail. We need the cooperation of all practicing physicians in solving our problems. We should not leave it to the legislators alone.

VaMPAC is a fund-raising organization. Unfortunately, in spite of great needs, we have had a decrease in membership this year. We need your cooperation at this time so we may continue these activities. Support VaMPAC now—to protect the future of medicine in the Commonwealth.

Barbara A. Mella, MD

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J. Thomas Hulvey, MD, Abingdon
James A. Shield, Jr., MD, Richmond

HOSPITAL MEDICAL STAFF SECTION

Participates twice yearly in the AMA Hospital Medical Staff Section to debate critical medical staff issues. Also meets locally twice a year.

John M. O'Bannon III, MD, Richmond, Chairman
Timothy A. Mjos, MD, Kilmarnock, Councilor-at-Large
Kearfott M. Stone, MD, Gloucester
Charles E. Ives, MD, Norfolk
Dennis A. J. Morey, MD, Richmond
William Coppedge, MD, Farmville
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Herbert A. Wood, MD, Winchester
Carol S. Shapiro, MD, Woodbridge
Carl E. Stark, MD, Wytheville
Thomas M. Fulcher, MD, Falls Church

AMA Delegates

The 144th Annual Meeting of the American Medical Association was held in Chicago on June 18-22, and representation from Virginia was the highest ever. In addition to our delegates and alternates and our President and President Elect, representatives from the Hospital Medical Staff Section and from three student medical societies were in attendance. We are also pleased to report that we had a representative from the Physician Resident Section.

There were 435 delegates seated—347 representing state associations, 78 representing national specialty societies, and ten section and service delegates.

Dr. Chris Alexander, Past President and delegate to the AMA, was elected to the Council on Medical Service. Dr. Alexander brings a wealth of knowledge to this Council and will do an outstanding job.

Among the major issues addressed by the AMA House of Delegates during the five-day session were expenditure targets, health issues for the uninsured, misleading explanation of benefits by third-party carriers, Medicare reimbursement, and the resource-based relative value scale for physician services.

Percy Wootton, MD

Hospital Medical Staff Section

The 13th session of the MSV Hospital Medical Staff Section met at the AMA meeting in Chicago June 15-18, where the national section registered over 600 delegates. Several critical issues were discussed which impact strongly on medical staff members here in Virginia:

Peer Review. As a result of adverse rulings in several antitrust cases, the concept of peer review is under attack. Peer Review is an integral part of medical staff activities, and the ability to do honest, good-faith peer review is absolutely necessary to ensure quality care. We must all work together to guard against erosion of this most valid concept.

National Practitioner Data Bank. This item, mandated by the federal government as a result of the Health Care Quality Improvement Act of 1986, will be operational before the end of 1989. Each medical staff office must report adversive credential actions to the Data Bank and must request information from the Bank every two years to avoid potential discovery of information by plaintiff's attorneys.

Medical Staff Autonomy. In today's complex hospital setting there are numerous organizations, including MSVRO, JCAHO, other review agencies, and insurance carriers, seeking to oversee and control medical care. It is extremely important that each hospital medical staff carefully guard its responsibilities to credential itself and direct the delivery of patient care in our hospitals. A medical staff has a specific responsibility: to formulate bylaws and rules for self-governance as well as maintain credentials and interact with the hospital board and other community organizations.

The Virginia Section invites all interested physicians to attend its annual meetings. The next one is scheduled for Thursday, November 9, 1989, 10 AM to 12 NOON at the Richmond Marriott. The program this year will include an update on federal legislation as well as details of the National Practitioner Data Bank. Please plan to attend and represent your hospital medical staff.

It is appropriate at this time to say a heartfelt "Thank You!" to Dr. George Carroll, who has so ably served as chairman of the Section since its inception seven years ago. Under his careful attention and direction the group has thrived and grown. While Dr. Carroll's attention is now directed to his new job as AMA alternate delegate, his presence in the Hospital Medical Staff Section will be sorely missed.

John M. O'Bannon III, MD

VIRGINIA MEDICAL

EDITORIAL

Commentary

Most membership surveys are simplistic in their design and the comments accompanying the answers are similarly unimaginative. In contrast, the recent questionnaire prepared for the Medical Society of Virginia and mailed to all Virginia physicians elicited some lively responses (see page 402) and most of these dealt with AMA/MSV unification.

Four years ago MSV leadership, with all good intentions, promoted unification; response of the membership was not as expected and a sizable number resigned from the Society. Should the question of unification be further explored? Opinion on that issue is divided. A vote by the membership has been suggested, but a large segment of those opposed to unification are no longer members of the Society. A vote by all those Virginia physicians who received the MSV survey is another possibility. Neither the study, method of study, nor the result would produce satisfaction for everyone, but the issue should be decided and permanently laid to rest.

Although the survey contained no questions in regard to Virginia Medical, a few respondents added comments in regard to the journal. These comments were generally favorable, but answer to one observation seems to be in order. To the writer who was concerned with the "poor literary and scientific quality of the journal": Where were you when we needed you? Instead of submitting your next red hot manuscript to the *New England Journal of Medicine*, send it here. We would love to have it. Seriously, while we try to project a mixture of politics, medical news, and scientific articles, the volume of good scientific material presently submitted to Virginia Medical is limited. More would be welcome. E. L. K., Jr.

A True Friend

Especially after a long, hard week, I can be very moody, behaving as though I have a divine right to be sulky. And this was one of those days when I was yielding to my inclination to be nasty.

My good friend Walter, who lives near my farm in the mountains of Patrick County, is severely handicapped by advanced heart disease, but he refuses to give up. He huffs and puffs after the slightest exertion, but he keeps on going.

He had come over to my farm on his riding mower, had mowed the lawn, and had fixed a fence gate, but on that particular day his repair job did not quite satisfy my surly nature. Usually it would have been just fine. And he had spontaneously done the chore as a favor to me out of the goodness of his seriously diseased heart. But I was in a bad mood, and irrationally I began to pick fault with what he had done for me.

Fortunately for me he realized that my mood was atypical and transient. As the ultimate in a friendly putdown, he gently reminded me, "Doc, you are forgetting something. You can't fire me because you never hired me."

H. S. Campell, MD

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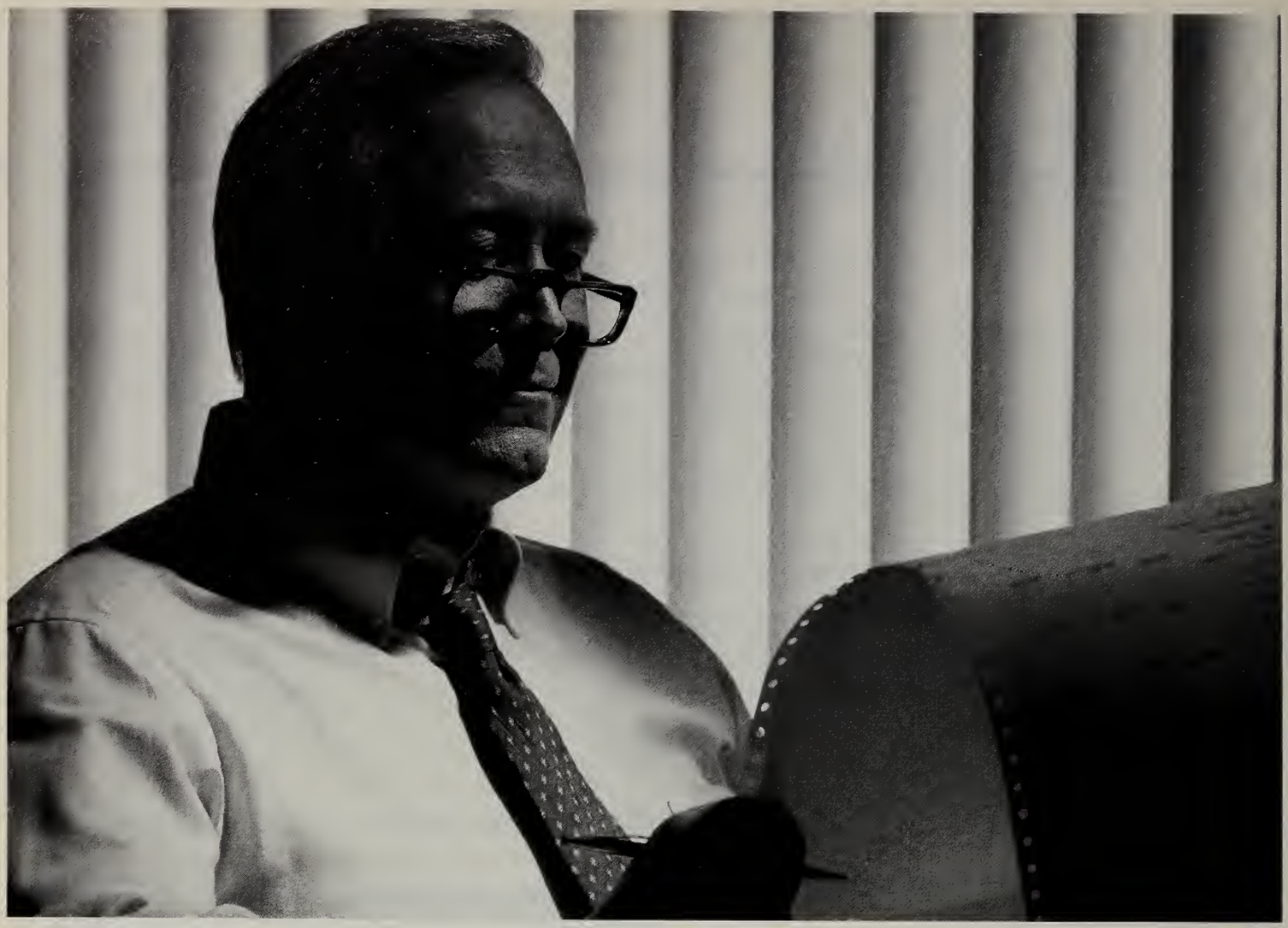

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Across the River and Into the Halls of Congress

THESE PICTURES were taken early in May at the 1989 Congressional Luncheon, which brought together in Washington the Medical Society of Virginia's leadership and Virginia's senators and representatives. This year the event was held in the Vandenburg Room of the Capitol Building.

Upper right, Rep. L. P. Payne, Jr. (D-5th District), listens to Dr. George E. Broman, Speaker of the MSV House.

Right, Rep. Frank R. Wolf (R-10th District), has the attention of Dr. Barbara Mella, VaMPAC chairman, and Dr. Ira D. Godwin, 10th district councilor.

Below, Virginia's former Governor and now Senator, Charles S. Robb, sat next to MSV President J. Thomas Hulvey.

Photographs by Mark Charette

Still paying premiums without hope of a return?

LETTERS

Somehow the word got out without our help

Somehow I have failed to find any reference in VIRGINIA MEDICAL to the top salary paid to the Executive Vice President of the American Medical Association. To the tune of $697,718, it is the highest among executives listed in the *Washington Post* and *Medical Economics*. That's the equivalent of 1,836 AMA membership dues, just to cover one person's salary.

Virginia physicians, unify. ALL FOR ONE.

Laszlo C. Steingaszner, MD
Potomac Hospital Corporation
2300 Opitz Boulevard
Woodbridge VA 22191

Editors' Note: Dr. Steingaszner is correct. Va Med did not give space to this statistic, for the simple reason that it was so resoundingly reported elsewhere.

Offers treatment plan for "the most dangerous drug"

With a death rate exceeding 1,000 a day in this country,[1] smoking is the modern version of the plague and nicotine the most dangerous drug. (The death rate from alcohol abuse is about 100 per day and from cocaine, 15–20 per day.[1]).

Various methods are used to help patients. Each must include these four phases: 1) motivation, 2) pharmacological aids, 3) behavior modification, and 4) relapse prevention.

The use of the clonidine patch has been helpful because the neuroreceptor center for nicotine and for clonidine are both in the locus caeruleus, a very small area in the midbrain. Clonidine takes three days to reach a maximum level when administered by the patch method. Therefore, establish a quit date and apply the patch four days prior to that date. This will make it fairly easy to taper down (50% fewer cigarettes each day) to achieve zero consumption on day four, although some patients need a little longer.

The first followup office visit should be one week after the start of the program, when over half of the patients will have stopped smoking. This is the appropriate time to discuss the side effects, most of which are the result of the nicotine cessation. Lethargy is reported in 40–50% of the patients, sometimes with dry mouth, constipation, orthostatic symptoms and pruritis at the patch site, and about 15% of the patients develop contact dermatitis, which is treated with reassurance and a steroid cream.[1]

The patch comes in three sizes equivalent to 0.1, 0.2 and 0.3 mgm clonidine absorbed each day. The number two size is a good starter, and if the patient is not successful at two weeks, the number three size may be used. The patch is changed weekly and a total of four patches is the usual prescription.

Behavior modification is stressed at each office visit. Patients are urged to change their life style to avoid the triggers associated with smoking. Mild exercise immediately after eating helps, as does the avoidance of friends who smoke. Positive substitutes, such as carrot sticks or cinnamon sticks or a glass of ice water on the desk, help some. Patients need to know that the addictive urge lasts only 3–5 minutes, not a long time to "white knuckle" it.

Nicotine dependence is an addiction and after stopping, one cigarette constitutes a relapse and usually leads to a pack a day resumption. Patients need to know that stress times are relapse risks.

It is important to examine the patient's lungs and comment as the ronchi disappear. The patients cough should clear in the third week and exercise capacity will increase. The taste buds "wake up" and begin to function again, the result being a weight gain of about 7 pounds. This is counteracted by a walking program of about 2 miles a day. After three months the weight should return to the smoking level.

The health benefits from smoking cessation appear promptly. In two weeks the chances of a myocardial infarction have been reduced by 50%! The cough gradually clears, the clothes and the house begin to smell better and you have given the patient another twelve years (average) of good living.

It is worth the effort on the part of both physician and patient to try.

Charles G. Smith, MD
1715 North George Mason Drive
Arlington VA 22205

1. Speech by Max Schneider, MD, University of California at Irvine, before the 1st Conference on Nicotine, Minneapolis, October 1988

The subject of smoking: More emotion than scientific truth?

The editorial note in the June issue of VIRGINIA MEDICAL[1] and an issue about a year ago devoted to tobacco[2] have caused a lot of thought and the concern that the subject may have become more wrapped in emotion than in scientific truth.

The lay press, the Surgeon General, and several prominent health organizations take it as a given that cigarette smoking causes several types of cancer, as well as emphysema and heart disease. The medical press on the other hand, although not nearly so

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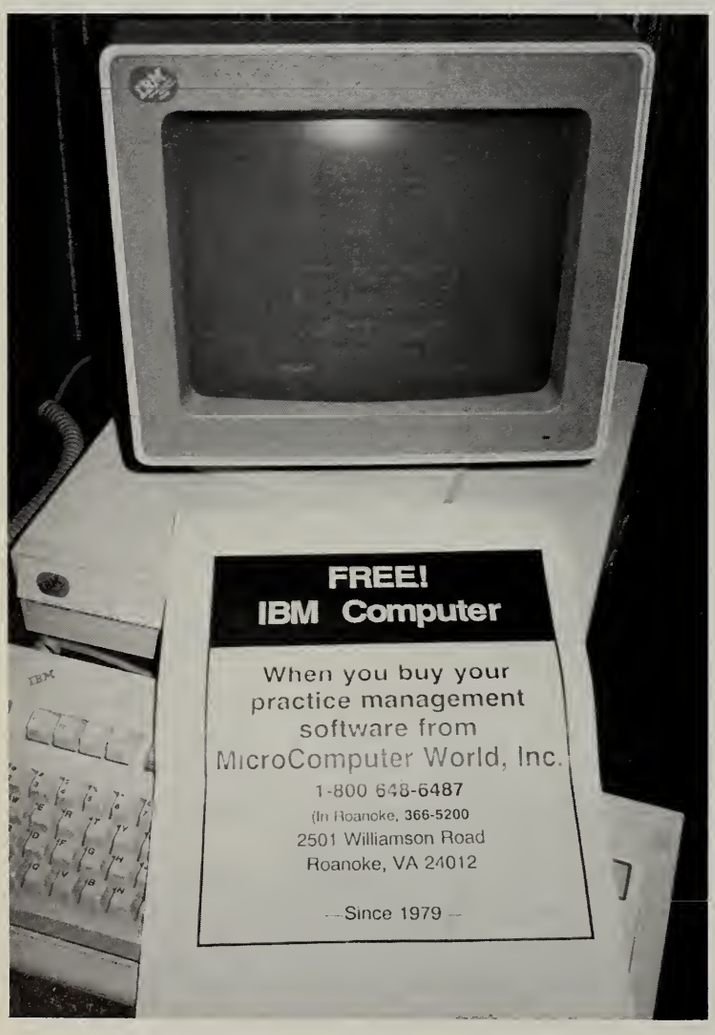

emphatic, has provided the data upon which these conclusions are based, data that is primarily statistical. The public response has been an almost religious fervor to rid the world of tobacco products by those who are susceptible to that kind of behavior, a pattern historically atypical of serious scientists.

In the past whenever physicians have forgotten that disease is a biological phenomenon and not a statistical one they have almost always gone off on the wrong track. Until the promulgation of Koch's principles almost all medicine had been deductive, statistical and empiric. This had allowed otherwise highly intelligent and thoughtful physicians to conclude that gout was a disease of overindulgence. However, the cause of it was unknown until it was shown to be the result of an inborn error of metabolism, genetically determined and inherited. In a similar but far less elegant fashion it was thought to be statistically proven that consumption was caused by cigarettes until the tuberculin bacillus was identified.

On the other hand, statistics were never necessary to demonstrate that smoking exacerbated vasospastic diseases, as well as upper and lower airway diseases. But that is a very different thing from saying that cigarette smoking is etiologic. It may make no difference to self-appointed protectors of society or to those who just don't like cigarettes, but it should make a great deal of difference to physicians and scientists.

Already a gene locus for small cell carcinoma of the lung has been identified on chromosome 3, as well as genes for other diseases on that and other chromosomes. Much of this has been brought to the public's attention on television and in newspapers and magazines. The primacy of heredity in the determination of health so long suppressed in the pursuit of environmental determinism and all its political ramifications is becoming more and more obvious as the secrets of gene and chromosome function are brought to light, demonstrating the biological rather than the statistical nature of disease.

To allow ourselves to be trapped, as we were in the cigarette-tuberculosis fiasco, in a new cigarette-and-every-disease-you-can-name fiasco is only to give ammunition to some modern day Molière to continue the mockery of the profession whilst diverting funds and inquisitive minds from proper basic research. As Dr. Harry Walker of the Medical College of Virginia used to say, There is nothing more dangerous in medicine than a deep feeler and a shallow thinker.

Stuart Ragland, Jr., MD

Yacht Wahconda
PO Box 24044, Gallows Bay
St. Croix USVI 00824

1. Kendig ELjr. More on smoking bans. Va Med 1989;116:279
2. Gray AG, Kendig ELjr. Smoking in Virginia's hospitals. 1988;115:526-530

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WHO'S WHO

Three Medical Society of Virginia members have been singled out for appointment by Virginia's Gov. Gerald L. Baliles.

Dr. Charles H. Crowder, Jr., South Hill family physician and MSV vice councilor, has been appointed to the Virginia State Board of Medicine.

Dr. Bernard Grand, Alexandria internist, was chosen by the Governor for appointment to the Virginia Voluntary Formulary Board.

Dr. Joel J. Silverman, Richmond, was the Governor's selection to fill a slot on the Joint Subcommittee to Study Certain Practices Among Psychiatric Professionals and Institutions. He is chairman of the department of psychiatry at the Medical College of Virginia/VCU.

Dr. Gerald J. Bechamps, Winchester, a member of the Virginia State Board of Medicine since 1980 and its president in 1985–1986, has been elected to the board of directors of the Federation of State Medical Boards of the United States. His election occurred at the Federation's annual meeting in Chicago. A surgeon, Dr. Bechamps is a graduate of the Georgetown University School of Medicine. The Federation is the national voluntary representative association of all United States medical licensing and disciplinary boards.

Dr. George W. Vetrovec, Richmond cardiologist, has been elected vice president of the national board of directors of the American Heart Association. Professor of medicine at the Medical College of Virginia/VCU, Dr. Vetrovec was president of the Association's Virginia affiliate in 1984.

New president-elect of the American Society of Pediatric Nephrology is **Dr. Petro A. Jose**, Mason Neck, professor of pediatrics at Georgetown University Medical Center. Dr. Jose was awarded his doctorate in medicine degree by the University of Santo Tomas in the Philippines in 1965 and joined the Georgetown faculty in 1970. The Society he is to head focuses on research into the care of children with kidney disease.

Dr. John W. Baker, Jr., Norfolk, is the new president of the Virginia Surgical Society. A native of Suffolk, Dr. Baker was graduated from the University of Virginia School of Medicine in 1968 and established his private practice of general and thoracic surgery in 1974.

Members of the Culpeper County Medical Society have elected **Dr. Joel R. Poole** as their new president and as secretary-treasurer, **Dr. Michael W. Russell**.

New president of the Portsmouth Academy of Medicine is **Dr. E. Daniel Kay**. The new secretary is **Dr. Kasedul Hoq**.

Dr. Francis E. Watson, MD, is the new president of the Chesapeake Medical Society. **Dr. Adam Billet** is the new secretary.

For his service as physician and citizen, **Dr. O. Hunter McClung, Jr.**, Lexington family physician, received an honorary doctorate in science from Washington and Lee University during commencement exercises. Dr. McClung, a graduate of the University of Virginia School of Medicine, served on the Lexington city council from 1961 to 1971.

Dr. Robert M. Epstein, chairman of the department of anesthesiology at the University of Virginia, Charlottesville, has been elected to the national Academy of Sciences' Institute of Medicine. Dr. Epstein joined the UVa faculty in 1972 and has published widely on the effects of anesthesia on circulation.

Fellowship in the American College of Obstetricians and Gynecologists was conferred on **Dr. William E. Broach III**, Danville, at a ceremony during the College's recent meeting in Atlanta.

Dr. Robert D. Keeling, South Hill, was made a fellow of the American College of Occupational Medicine during its annual convention in San Antonio. Dr. Keeling is a fellow also of the American Academy of Family Practice.

At its annual meeting in Seattle, the American College of Radiology conferred fellowships on these three Medical Society of Virginia members: **Dr. Donald M. Callahan**, Harrisonburg, **Dr. Morton L. Moss**, McLean, and **Dr. William E. Painter**, Lynchburg.

Dr. Charles E. Horton, Norfolk plastic surgeon, headed a recent 10-day Physicians for Peace mission to Eastern and Northern Turkey. A United States team of seven doctors and an Eastern Virginia Medical School student was joined by eight Turkish doctors and one nurse; together they visited cities in an infrequently traveled area near the Iraqi border, performing reconstructive surgery and giving lectures.

Dr. Horton prefaced the mission by attending the European and Asian Pacific sections of the International Confederation for Plastic and Reconstructive Surgery in Istanbul.

Dr. Percy Wootton, Richmond cardiologist, has been elected to two American Medical Association bodies: the Section Council on Cardiovascular Disease (as a representative of the American College of Cardiology) and the Executive Committee of the AMA Council on Legislation. A

Past President of the Medical Society of Virginia, Dr. Wootton currently serves as an MSV delegate to the AMA.

Five Medical Society of Virginia members received awards during graduation ceremonies at Eastern Virginia Medical School in June. For excellence in teaching, **Dr. Stephen D. Wohlgemuth** and **Dr. L. Delano Britt**, both from the department of surgery, were selected by the Class of 1989 for the Sir William Osler Award, and these three were given the first annual Dean's Faculty Achievement Awards: **Dr. Anas M. El-Mahdi**, chairman, department of radiation oncology and biophysics; **Dr. Howard W. Jones, Jr.**, professor of ob/gyn and president of the Jones Institute for Reproductive Medicine; and **Dr. Charles J. Devine, Jr.**, professor of urology with the EVMS community faculty.

The 1989 Outstanding Medical Alumnus Award of the University of Virginia Medical Foundation went to **Dr. Weir M. Tucker**, Richmond, a 1942 graduate of the UVa School of Medicine and a specialist in neurology and psychiatry.

Radford Community Hospital has a new medical staff president. He is pathologist **Dr. Antonio Perez**, a graduate of the Havana University School of Medicine, whose wife, **Dr. Ana Perez**, is also a clinical pathologist at the same hospital.

For his services as country doctor and local historian, **Dr. W. R. Chitwood, Sr.**, Wytheville, was given the 1989 Outstanding Citizen of the Year award by the Wytheville-Wythe-Bland Chamber of Commerce. A Wythe County native, Dr. Chitwood was graduated from the University of Virginia School of Medicine and entered practice with his father, the late Dr. E. M. Chitwood, Sr., in 1948. Since his retirement in 1965 he has written several books and articles on the history of Wythe County.

In the American Lung Association of Virginia's quarterly publication, *Airways*, **Dr. William F. Cale**, pulmonary specialist in Harrisonburg, is the subject of a "volunteer close-up" for his long-time support of the ALA. Now president of the Association's Shenandoah Region, Dr. Cale is active in fund-raising activities and frequently speaks on asthma and chronic lung disease.

Help is on the way. **Three of the six doctors in this photograph represent 100 years of practice in Emporia. The other three are their sons, who were graduated in June from the Medical College of Virginia/VCU and who intend to return to Emporia to give their dads a hand. From left are Dr. Thomas A. Walker and Dr. Stephen T. Walker; Dr. Peter W. Squire and Dr. Robert Hall Squire; and Dr. John S. Prince and Dr. John S. Prince, Jr. The fathers are MCV graduates, too, and all three are family physicians in Emporia, where they comprise 25% of the town's 12-physician force. Dr. Prince and Dr. Squire are partners in a clinic, Dr. Walker has a solo practice across the street from them. Their sons are training in family practice (Dr. Squire), internal medicine (Drs. Walker and Prince), and pediatrics (Dr. Walker). The picture was taken at MCV commencement exercises by Virginia Walker, proud wife and mother, who graciously loaned it for publication.**

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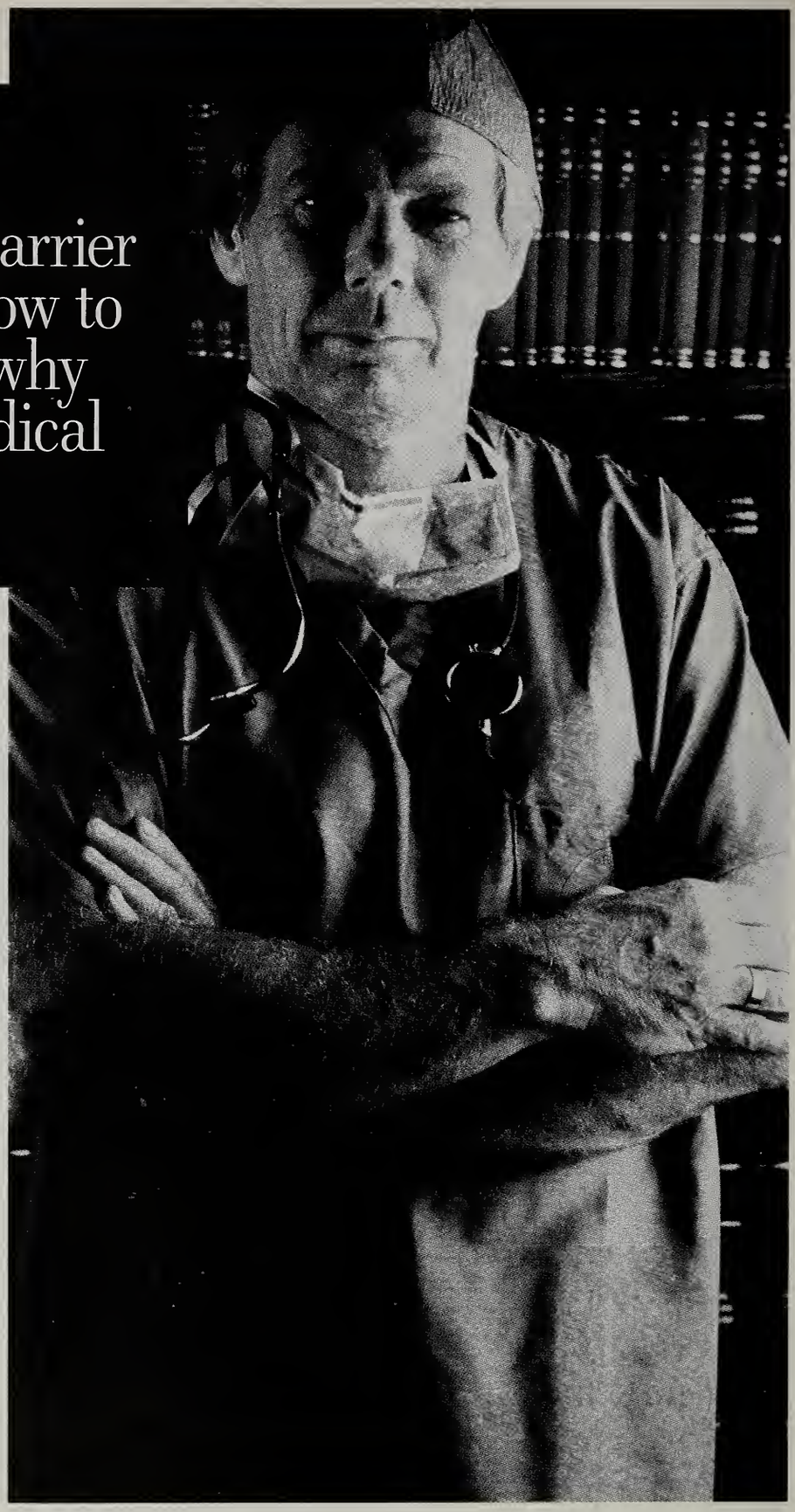

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Jaime Polit, MD, Internal Medicine, 502 East Main Street, Marion VA 24354

Robert E. Pryor, MD, Internal Medicine, 199 Hospital Drive, Galax VA 24333

James L. Van Dyke, MD, Anesthesiology, 102 Hunt Club Road, Abingdon VA 24210

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Suzanne S. Love, MD, Emergency Medicine, 2605 Thirza Place, Virginia Beach VA 23454

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Rex B. Waterbury, MD, Obstetrics/Gynecology, 915 First Colonial Road, Virginia Beach VA 23454

Renee A. Woodford, MD, 1000 First Colonial Road, Virginia Beach VA 23454

Residents

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David F. Butler, MD, Radiation Oncology, 2630 Marrow Drive, Newport News VA 23606

Raymond M. Dunn, MD, Plastic Surgery, 827 Botetourt Gardens, Norfolk VA 23507

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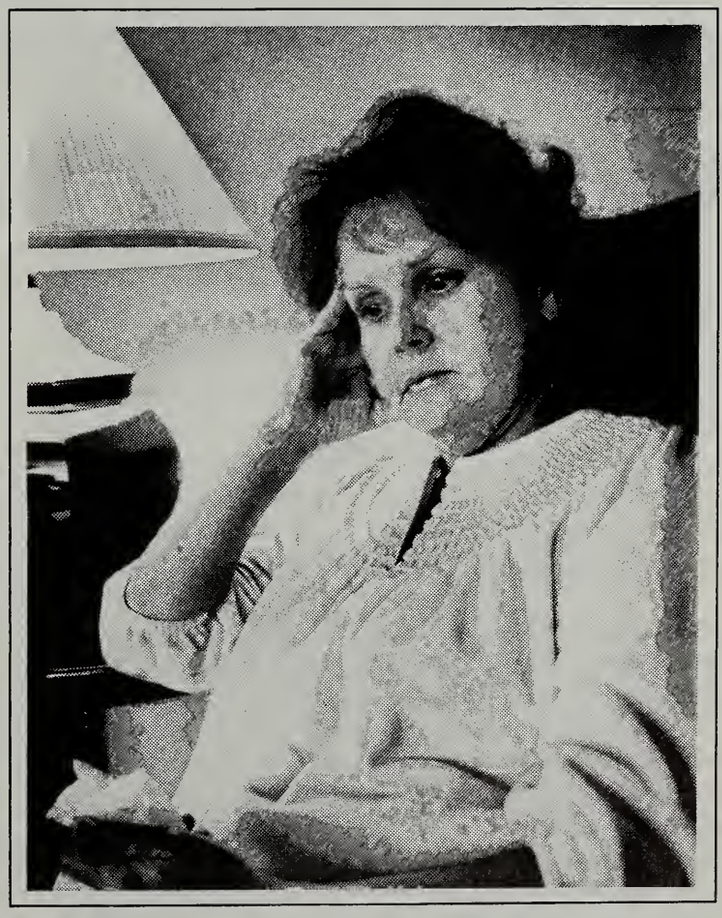

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Decisions to Forego Life-Sustaining Treatment

John C. Fletcher, PhD, *Charlottesville, Virginia*

Decisions not to start or to stop life-sustaining technologies raise the most frequent ethical problems in clinical and long-term care settings in the United States. At the University of Virginia Hospitals, 66% of the requests for ethics consultation concern decisions to forego treatment.[1] The decision is especially hard in cases when death is the only alternative to starting or stopping treatment that is costly in pain and suffering as well as resources. The author presents five maxims, fitting five common dilemmas, to help guide the physician in making such decisions.

MEDICAL ETHICS, an ancient discipline, was always a subset of general social ethics. A new field, biomedical ethics, emerged in the last 25 years to study ethical problems in medicine and other life sciences under general social ethics. Biomedical ethics tends to be the preferred term today because it includes concerns about biomedical research and the societal problems of medical technologies.

A subfield called "clinical ethics" has also emerged. Clinical ethics involves the identification, analysis and resolution of ethical problems in the care of patients. This term is also more inclusive than "medical ethics," which suggests that those trained in medicine have a special place in the ethical arena. Physicians are indeed therapeutic authorities and leaders in the clinical setting. However, in ethical problems in patient care the President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research advised emphasis on the capable patient's decision in a context of shared decision-making.[2] "Shared" means involvement of all in the clinical setting with ethically relevant knowledge of the patient.

Maxims in ethics create a bridge between broader concerns of biomedical ethics and judgments in particular cases. The word "maxim" comes from the Latin, *maxima senteniae*, which literally means "long sentences." Maxims are longer than moral rules, e.g., "Do not lie," "Do not cause unnecessary pain," etc., because they apply to a particular family of cases rather than social life in general. A maxim is a short summary of ethical guidance about the best approaches to types of ethically problematic cases. As such, a maxim is like a standard of care for an optimal approach to an ethical problem.

Two older ethical distinctions, taught as maxims and

John C. Fletcher became Director of the University of Virginia's Center for Biomedical Ethics in 1987 following ten years as chief of the bioethics program at the Clinical Center of the National Institutes of Health. He is an ordained Episcopal priest with a PhD in Christian ethics and was a founding fellow of the renowned Hastings Center for research and education in bioethics and a founder and first president of the new national Society of Bioethics Consultation. Address correspondence to him at Box 348, University of Virginia Health Sciences Center, Charlottesville VA 22908.

widely used, now prove to be less than helpful, or even misleading, in decisions about foregoing treatment. Foremost was the distinction between "ordinary" and "extraordinary" (also called "heroic" or "artifical") treatment. If a treatment was deemed ordinary, it was obligatory; if it was extraordinary, it was optional. But in a modern critical care setting, what is "ordinary" and what is "extraordinary?" Technology cut the legs out from under this maxim's usefulness in today's clinical setting.

The second familiar distinction was between an "act" (leading to death) and an "omission" (leading to death). At face value, to act appeared to be more culpable morally than to omit to act. Many doctors and nurses still believe that it is morally harder to withdraw than to withhold life-sustaining treatment, but as Maxim Two below points out, this attitude is flawed.

The barethreadedness of these older tools in ethics was not always the case. There was a fulsome meaning of the original ordinary/extraordinary distinction that is still cogent today. Catholic moral theologians, like Banez, used it as long ago as 1595 in almost the same sense as in Maxim Two.[2] While holding it to be reasonable that a person must try to maintain his or her life, Banez taught that it was not obligatory to use "extraordinary" means, but only to preserve life by nourishment, medicine, clothing, and even from pain and anguish (*dolorem*) "common to all." He continued that any extraordinary or horrible pain or deeds (*sumptos*) extraordinarily disproportionate to one's state of life was not required.

The growth of technologies in critical care confused the original meaning of ordinary/extraordinary care, and conflicts broke out about such decisions between the 1960s and 1980s. The problem in the Sixties centered around kidney dialysis. In the Seventies the focus shifted to ventilation machines. In the Eighties the controversy shifted to "artificial" feeding and hydration.

In 1983 the report of the President's Commission recommended that the main approach to decision-making in this area should be based on the proportionate benefits and burdens of each life-sustaining treatment. Several other distinguished bodies followed with recommendations for ethical guidance: the American Medical Association (1986),[3] the Office of Technology Assessment (1987),[4] and a Hastings Center interdisciplinary taskforce (1987).[5] The maxims below, except for the fifth, derive in large part from the reports of these bodies. Their specific wording was developed by ethicists and physicians at the University of Virginia. Maxim Two is the major maxim in the sense that all decisions to forego treatment ought to conform to it. Maxim One, however, is the most overriding maxim (with one exception), even when physicians have solid evidence that the benefits of treatment outweigh the burdens.

Maxim One: The Capable Patient (With One Exception)

The Dilemma: *A capable (competent) person refuses life-sustaining treatment, but health care professionals or family members disagree with the choice and feel that they must act on their objection.*

The Maxim: Decisions to forego life-sustaining treatment, like all other health care choices, rest finally with the capable patient in a shared decision-making process between physician, patient, family and others caring for the patient.

The one exception to this maxim is when the patient is capable but demands that clearly futile treatment be started; physicians can ethically refuse to acquiesce and should seek to resolve the ethical dispute.

The case of Elizabeth Bouvia[6] clearly illustrates a violation of Maxim One because a nasogastric tube was forced on a debilitated but competent patient with cerebral palsy who refused treatment because she desired to die.

Maxim Two: Benefit/Burden, The Major Maxim

The Dilemma: *Disputes arise among health care professionals or between them and the family about the most ethically sound basis for making decisions to forego life-sustaining treatment.*

The Maxim: The distinction between the benefits and the burdens of each treatment that sustains life is the most ethically sound approach to choices to forego. When the benefits of treatment clearly outweigh the burdens, it is obligatory to give treatment, with one exception, and that is when the capable patient refuses it. It is optional to forego treatment when the burdens of a particular treatment or treatments clearly outweigh any possible benefits.

The Clarence Herbert case, in which two California physicians were charged with homicide (and exonerated) after they granted the requests of a patient's family to stop a respirator and IV feeding/hydration, clearly illustrates this maxim.[7]

Maxim Three: Maxim Two Has No Exceptions

The Dilemma: *Disputes arise as to whether specific treatments, e.g., feeding, hydration, antibiotics, etc., ought always to be started or continued, regardless of the prognosis of the patient.*

The Maxim: Conventional wisdom that withdrawing is morally harder than withholding is flawed. The choice not to start treatment that may be barely beneficial or questionably futile ought to be morally harder than to withhold any treatment that has proved futile, assum-

ing that standards of substituted judgment (for once-capable patients) or "best medical interests" (for never-capable patients) have been met.

The Nancy Cruzan case tests Maxims Two and Three.[8] In this case, the Missouri Supreme Court has ruled that the State has an interest in protecting the life of an individual, even if he or she is in a persistent vegetative state, by not permitting withdrawal of artificial feeding and hydration. The bearing of Maxim Two on feeding and hydration is controversial, but the prevalent moral view regards all treatments as morally similar, placing the burden of proof on those who argue to the contrary.

The Linares case, in which a father unplugged his child's respirator at gunpoint and held the child until he died, is a tragic example of the fallacy involved in claiming that withdrawing is morally (and legally) harder than withholding treatment.[9,10]

Maxim Four: The Duty To Inform

The Dilemma: *When physicians decide that particular treatments are futile and should not be tried or started, must the patient and family always be informed? Disputes arise about the duty to inform when it is felt that the information will itself further "burden" the patient or family.*

The Maxim: Physicians have a duty to inform the capable patient or the family of the incapacitated patient as to recommendations to withhold or withdraw treatments that may be life-sustaining but are futile or extremely burdensome. Morally, the duty to inform falls within the larger scope of duties to disclose poor prognosis and to limit medical care when rational approaches to therapy have failed.[11]

Maxim Five: Disputes With Surrogates

The Dilemma: *In cases of incapacitated (incompetent) patients, when disputes arise between surrogate decision-makers (family or guardians) and physicians about starting or stopping life-sustaining technologies, must there be a "failsafe" policy to treat under all circumstances while the dispute is being resolved? The President's Commission recommended such a policy about disputes involving cardiopulmonary resuscitation. But is the policy the right one? Are there any exceptions?*

The Maxim: In ethical disagreements with surrogate decision-makers, the policy is to treat until the dispute is resolved, with one exception, as follows.

If the guardian or family of an incapacitated patient without any written advance directives demand

a) that beneficial treatment for the patient be withheld, physicians should not acquiesce and should seek to resolve the dispute by ethics consultation and begin treatment by court order if necessary, placing the best medical interests of the patient above all other considerations;

b) that beneficial treatment for the patient be withdrawn, physicians should not acquiesce and should seek to resolve the dispute by ethics consultation and continue to treat by court order if necessary;

c) that clearly futile treatment be continued, physicians should respectfully disagree and continue treatment with consideration of a deadline while seeking to resolve the dispute by ethics consultation;

d) that clearly futile treatment be started, after good faith efforts to resolve the dispute by ethics consultation, physicians should withhold futile treatment, even over the objections of guardians or family members.

At Massachusetts General Hospital, section d) was applied in 20 cases, avoiding harm to the patients of the futile use of CPR and without any law suits by families, even though threats were made in all cases.[12]

Maxim Five is the newest and least settled in the set of maxims and section d) would be experimental and controversial in almost any clinical setting at this time. Studies of the efficacy of the section ought to be designed as research and approved by an institutional review board. The purpose of such studies would be to document any harm done by the failsafe policy of continuing treatment in the context of all types of disputes. Maxim Five presumes that this approach needs reform in one facet, and that is to permit withholding of clearly futile treatment (e.g., CPR) over family demands that it be started.

Ethical Grounds for the Maxims

Maxim One is grounded in respect for persons and their autonomy and is consistent with approaches to informed consent and refusal. Maxim Four is also grounded in respect for persons and is akin to the informed consent maxim.

Maxim Two originates mainly in the principle of proportionality and also affirms that physicians should avoid doing harm by futile treatments. The ethical ground of Maxim Three is the same.

Maxim Five is grounded in a basic ethical premise to favor sustaining life, especially in the midst of a dispute about treatment, while vigorously seeking to resolve the dispute on ethical grounds out of respect for the family or appointed surrogates. The one exception in Maxim Five originates in the nonmaleficence principle (Do not harm others). A surrogate's desires that clearly futile treatment be started can be ethically refused by physicians to minimize harm to the patient. To take this position, physicians should be willing to subject their medical judgment to withhold treatment to a court of law.

Section c) of Maxim Five recommends against uni-

lateral withdrawal by physicians of life-sustaining technologies over a family's or guardian's desires to continue it, even if the treatment is clearly futile. The physicians should seek pastoral counselling for the family and ethics consultation, but if this mediation does not resolve the dispute, treatment should be continued. Although this step compromises Maxim Three, withdrawing life-sustaining treatment over the objections of family members could cause them great psychological harm and distress and also carries heavy legal risks. This compromise also permits family members to be the final interpreters of the patient's and the family's quality of life.

The author wishes to acknowledge the contributions to the conceptual background of this article of Mary Faith Marshall, RN, and Rosalyn W. Berne, MA, both of whom are candidates for the PhD degree (biomedical ethics) in the Department of Religious Studies at the University of Virginia.

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Help for a troubled friend is only a phone call away.

If you suspect a colleague is experiencing problems with alcohol or drug abuse, don't contribute to the "conspiracy of silence," call The Medical Society of Virginia's Physicians' Health and Effectiveness Committee. A non-punitive approach through rehabilitation *is* an alternative. Your report will be kept confidential. Ask for Jeanne Douglas at MSV headquarters, (804) 353-2721.

POINT OF VIEW

Hoist by an HMO's Fine Print

When I moved to Richmond in 1986, like any new practitioner I agreed to participate in several of the HMO/PPO plans in the area. I felt that these plans were primarily interested in quality while taking appropriate steps to control health care costs. I recount here my experience with one of these plans, which I joined on October 1, 1986. The contract seemed fair and allowed either the HMO or me to terminate the yearly contract if notice was given 90 days prior to the end of the contract.

My participation in this HMO was uneventful and eventually it accounted for approximately 10% of my revenues. As one of the few minority providers in my specialty, I found that my patients were quite satisfied and it appeared I was filling a need for the HMO.

I was amazed to receive a letter from the medical director of the HMO on July 1, 1989, which stated, without explanation, that my participation with the HMO was to be terminated as of August 1, 1989. Since my medical expertise and care delivery had never been challenged, I requested an explanation as to why such action was being taken.

The hospital administrator of my primary hospital also wrote to the HMO on my behalf. Neither of us received a response. Finally I contacted an attorney to find out what was happening. After two letters from my attorney (the last threatening legal action), a letter finally was sent to me. "We do not have *to have cause* to terminate any participating doctor," it said. "We are not required to give any advance notice of termination (and we were kind enough to give you 30 days notice)." When my attorney pointed out that the contract termination clause required 90 days notice prior to the end of the contract year, the HMO medical director stated that the contract had been unilaterally changed on January 1, 1989, to allow the HMO to terminate without cause at any time.

In essence, my yearly contract with the HMO had been changed to a day-to-day contract, and the HMO did not extend a similar right to me to terminate my participation with the HMO. I was still held to the 90 days notice requirements. Since I did not remember receiving any such contract modification, the HMO obligingly gave me a copy along with the modification cover letter. It said in part, *Effective January 1, 1989, [HMO name] will implement new contractual modifications. The amendments reflecting these modifications are attached. We believe these changes will have a positive impact on your HMO . . . participation.* The cover letter certainly would not alert anyone to the fact that a very important contractual right had been stripped away. But buried in a paragraph at the end of page two of the amendments was the sentence: *This agreement may be terminated with or without cause by HMO effective immediately upon written notice at any time during the term of the Agreement.*

To convert a yearly contract to a day-to-day contract is certainly a significant change and could hardly "have a positive impact" on my participation.

How did this happen? Like many contracts of adhesion (contracts in which one party has much bargaining power than the other), the original contract I signed had a clause under the heading of "Miscellaneous" which gave the HMO the power to take away any of my contract rights with only 30 days notice. It reads: *This Agreement may be amended or modified in writing as mutually agreed upon by the parties. In addition, HMO may modify any provision of this Agreement upon thirty (30) days prior written notice to Consultant Physician.* Obviously, the HMO used this stipulation to strip away a very important contractual right. If one were to have a disagreement with the HMO, the HMO could end the disagreement simply by terminating the complaining doctor!

Is there a lesson to be learned by my experience? Perhaps first and foremost we physicians should not be so trusting. We should read every HMO contract carefully and object to wording that can work against us. When the wording cannot be changed, we should "vote with our feet." No HMO can exist if the best of its physician members leave.

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M marinum Infections in a Chesapeake Bay Community

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Their proximity to Eastern Virginia's abundant waterways has given the authors experience in managing the destructive tenosynovitis and deep tissue infections caused by *M marinum*. They present nine cases, discuss diagnosis and treatment, review the literature, and urge urban physicians to be on the alert for the disease in patients recently returned from fishing trips.

An acid-fast organism that lives in an aquatic environment, *Mycobacterium marinum* is classified in Runyon's Group I of the atypical mycobacteria. It was first isolated from fish by Aronson in 1926.[1] An organism labeled *M balnei* in 1954 by Linell and Norden, who described an epidemic of swimming pool granulomas,[2] was conceded five years later to be identical to *M marinum*. (Of historical interest is the fact that the investigators of the 1954 study inoculated themselves with *M marinum* and produced typical skin granulomas from which they again cultured the organism.)

M marinum has been isolated from both fresh and salt water, including swimming pools and aquariums, and was initially thought to cause a benign superficial cutaneous infection. It is now known that *M marinum* may also cause a destructive tenosynovitis, deep tissue infections, and, rarely, osteomyelitis.[3]

The authors are on the medical staff of Rappahannock General Hospital in Kilmarnock, where the patients in this report were treated. Address correspondence to Dr. Hoyt at PO Box 1599, Kilmarnock VA 22482.

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Due to our close proximity to the Chesapeake Bay and its tributaries, we have had the opportunity to diagnose and treat nine cases of culture-proven *Mycobacterium marinum* in the past ten years. The following is a review of our experience and the literature.

Case Report

Case #2 of Table 1. A 65-year-old Chesapeake Bay waterman noted painful swelling in both wrists over several weeks. No other joints were involved and he had no constitutional symptoms. Frequent cuts and abrasions related to hauling a gill net and crab pots were noted. Initial medical management by three physicians consisted of rest, nonsteroidal antiinflammatory drugs (NSAIDS), splinting, and oral and intra-articular steroids for a presumptive diagnosis of seronegative rheumatoid arthritis. He failed to improve and returned to the orthopedist for a synovectomy. At that time the entire right wrist was swollen and erythematous, with areas of skin breakdown, drainage of purulent material, and obvious compromise of the function of the flexor tendons of the fourth and fifth fingers. Similar changes, though less in degree, were noted in the left wrist with mild restriction of flexion in the left hand.

Debridement under local anesthesia revealed extensive soft tissue destruction and involvement of tendons, nerves, and vascular structures in the right wrist. Erosion with incomplete rupture of the flexor tendons of the fourth and fifth fingers was noted. Aerobic and anaerobic cultures of the debrided areas were negative; histologic specimens showed chronic synovitis and inflammatory infiltrate with caseating granulomas. Acid-fast smears, however, were negative.

The patient was begun on ethambutol 15 mg per kg, rifampin 600 mg daily and minocycline 100 mg po bid. Progression to rupture of the flexor tendons of the fourth and fifth fingers on the right hand was noted over the next several weeks with partial flexion of the remaining digits of the right hand being present. The lesion on the left wrist remained static. Cultures of the debrided material grew *Mycobacterium marinum*, resistant to isoniazid. Because of the progression of the right wrist lesion, streptomycin 1 gram three times weekly and pyrazinamide 500 mg, po tid were added to his regimen. After two months of therapy, the lesions in both wrists had begun to improve, and ulceration and drainage gradually diminished.

After a total of 18 months of therapy, the patient had permanent loss of function in the right hand with inability to flex the fourth and fifth fingers and only limited capacity in the remaining fingers. The left hand showed recovery of 75% of function.

This is the only case in our series of nine that did not have an excellent or good outcome.

Summary of Cases

Our nine cases (Table 1) demonstrate some common features of this disease. Almost all cases resulted from saltwater puncture wounds or lacerations, and infection occurred almost exclusively on the hands and feet. Watermen and fishermen were particularly at risk, and a common mode of injury involved handling crabs or fish. Two-thirds of our cases involved males, which seems to be quite typical. Our series included more older people, most likely reflecting the demographics of our retirement community. The most common symptoms were pain, swelling and erythema of the involved extremity.

An important point to note is the frequent delays in making a correct diagnosis. This is not a common disease, and thus there was an average of 6-7 months between onset of symptoms and making the correct diagnosis. The indolent nature of the infection and lack of systemic toxicity frequently led to numerous ineffective trials of therapy. All cases were eventually confirmed by positive cultures obtained at the time of surgical debridement and submitted to the Virginia Consolidated State Laboratories. Only one Ziehl-Nielson smear was positive for acid-fast bacilli, and thus this is usually not helpful in diagnosis.

Clinical Manifestations

M marinum is a pathogen of salt and fresh water fish and is acquired by humans through abrasions, lacerations or punctures incurred in aquatic environments.

Table 1. Summary of Nine Cases of *M marinum* Infection Treated at Rappahannock General Hospital.

Pt. # Age/Sex	Exposure	Site of Involvement	Symptoms	Duration of Sx Before Correct Dx/Rx	Prior Therapy	Treatment		Outcome
						Antibiotic	Surgical	
#1, F.B. 71 y/o F	Crab puncture wound	Right hand	Swelling	1 month	None	Minocycline (6 weeks)	Excision granuloma	Excellent
#2, R.B. 65 y/o M	Saltwater puncture wound	Right and left wrist	Chronic drainage, swelling	8 months	NSAID	Rifampin, minocycline, ethambutol, streptomycin, pyrazinamide	Synovectomy, tendon repair	Poor
#3, C.C. 67 y/o M	Saltwater puncture wound	Right hand	Swelling	4 months	NSAID	Rifampin, minocycline, ethambutol	Synovectomy	Excellent
#4, J.H. 15 y/o F	Saltwater laceration	Foot	Swelling	1 week	N/A	Minocycline (6 weeks)	Debridement	Excellent
#5, J.J. 21 y/o M	Saltwater puncture	Hand	Pain, swelling	15 months	Antibiotics, debridement	Ethambutol + rifampin (3 months)	Debridement	Excellent
#6, P.M. 79 y/o M	Unknown	Toe and ankle	Pain, swelling	12 months	Steroid injections	Isoniazid + ethambutol	Amputation toe	Good
#7, H.O. 65 y/o M	Cleaning fish	Finger	Pain, swelling	31 months	Cephalosporin	Isoniazid + rifampin (6 months)	Synovectomy, debridement	Good
#8, K.S. 60 y/o M	Saltwater puncture wound	Finger	Pain, erythema	3 months	Cephradine	Minocycline	Debridement	Excellent
#9, J.S. 55 y/o F	Saltwater puncture wound	Foot	Pain, swelling	4 months	I&D × 2, sulfa, tetracycline	Minocycline	I&D	Excellent

Reports document infection by the organism in aquarium owners, skin divers, dolphin trainers, Chesapeake Bay swimmers, industrial workers and ship builders. The organism has been cultured from sea walls, boats, submerged cables and barnacles. Nonaquatic exposures have been documented from school desks, asphalt school yards, construction materials and rose thorns.[4,5,6]

Two-thirds of the patients in reported series are male and half are in the second decade of life. The incubation period ranges from two weeks to two months. The infections manifest as superficial and deep cutaneous infections. The superficial lesions, which usually range from one to six in number, are chronic, dusky, erythematous plaques or verrucoid papules or nodules in areas subject to trauma, such as knees, elbows and hands. Superficial lesions can appear as solitary granulomas or verrucous papules 1-2.5 cm in diameter that may ulcerate and drain purulent material. They also may occur as lymphatic sporotrichoid lesions and, rarely, as disseminated cutaneous papules.[7]

Deep infections usually involve the wrist and hand, producing a destructive tenosynovitis. Diffuse edema of the site of the infection is the most common sign. Characteristically, there is a slight fullness localized to the tendon sheath. The dorsum of the hand does not swell as in pyogenic infections and throbbing pain does not usually occur, but there is limitation of the range of motion with the eventual development of a draining sinus. Systemic complaints and lymphadenopathy are rare, and the temperature and erythrocyte sedimentation rate (ESR) are usually normal. There are no characteristic x-ray findings. Hand function is compromised because of involvement of extensor or flexor tendons. In deep infections, the duration between onset of symptoms and the time of correct diagnosis is reported at 3.5 months, and by the time of correct diagnosis, 54% of patients had received local steroid injections.[8]

The differential diagnosis of *M marinum* infection is extensive. It includes such infections as sporotrichosis, tularemia, nocardia, yaws, syphilis, leishmaniasis, common warts, coccidioidomycosis, blastomycosis, histoplasmosis, tuberculosis verrucosa cutis and other atypical mycobacterial infections. Systemic processes such as sarcoidosis, gout and rheumatoid arthritis may mimic *Mycobacterium marinum* infection. One must also consider iodine or bromine granuloma and benign or malignant tumors.[9]

Pathology

Biopsy specimens of infected tissue usually reveal hyperkeratosis, often with parakeratosis. The dermis contains a chronic granulomatous infiltrate of epitheloid cells and lymphocytes, and Langhans' giant cells are often present. Early in the course of the infection the granulomatous inflammation is diffuse, but later, organized tubercles develop. Some of these may exhibit caseous central necrosis. In tissue, the organism is often scant and poorly seen on acid-fast staining. When present they may be seen in clumps as short, thick and uniformly staining rods, or long, thin, beaded and barred bacilli scattered throughout the tissue. Immunofluorescent staining of *M marinum* is available and is more sensitive than AFB stains.

M marinum is a yellow photochromogen that grows best at 31°C and usually requires 10-30 days incubation on Lowenstein-Jensen medium. This relatively low temperature requirement may explain its apparent inability to cause visceral disease.[9,10,11]

Treatment

Treatment of localized cutaneous *Mycobacterium marinum* infections has included watchful waiting for spontaneous remission, local heat, electrodessication, x-ray therapy, Grenz ray therapy, ultraviolet light therapy, liquid nitrogen therapy, local excision and other surgical procedures, corticosteroids, potassium iodide and antibiotic therapy. As clinical experience has accumulated, antibiotic therapy has become the treatment of choice for cutaneous disease, whereas surgery and antibiotics are generally required for infections of deeper structures of the hand and wrist.

The three most frequently used chemotherapy regimens include antituberculous drugs, usually rifampin and ethambutol, tetracyclines, and trimethoprim-sulfamethoxazole. Early studies demonstrated resistance to isoniazid (INH), para-aminosalicyclic acid (PAS), thiosemicarbazone and variable resistance to streptomycin[2,12] rifampin and ethambutol.[13] Although successful treatment with rifampin alone has been reported,[14] it is not recommended as monotherapy because of the potential for emergence of resistant strains, a phenomenon seen with *H influenza* and *N meningitis* following rifampin prophylaxis.[15] Sixteen strains of *M marinum* were inhibited by trimethoprim-sulfamethoxazole,[16] although resistance to cotrimoxazole has been reported.[17] Thirteen of 17 patients treated with trimethoprim-sulfamethoxazole demonstrated complete or partial resolution of aquarium-borne *M marinum* skin infections without recurrence.[4] Torres et al[18] indicate that up to 72% of *M marinum* strains are sensitive to therapeutically achievable levels of doxycycline or minocycline. Six cases healed completely with 1-1.5 grams of tetracycline daily for 8-16 weeks[19] and similar successes have been shown with minocycline.[20,21]

Recommendations for length of therapy are variable, owing in part to the frequently self-limiting nature of *M marinum* infection. Kim[19] suggests at least 3 weeks of tetracycline therapy and Izumi[13] recommends 2 grams of tetracycline daily for 2-4 months. Huminer et al[4] reported success with trimethoprim-sulfamethoxazole 2 tablets twice daily for 6 weeks.

Brown and Sanders call for prospective studies that

compare tetracyclines or trimethoprim-sulfamethoxazole with rifampin plus ethambutol in the treatment of *M marinum* infections and suggest treating advanced disease and disease involving deeper structures with rifampin plus ethambutol. They recommended initiating therapy of minimal disease with doxycycline or trimethoprim-sulfamethoxazole while awaiting results of culture and sensitivity studies and observation of the clinical response.[15] Local corticosteroid injections are contraindicated as *M marinum* infection is frequently exacerbated.[22] Local heat is generally considered to be a useful adjunct to therapy.

Surgery is another mode of treatment for this infection, usually employed when a worsening infection of deep tissues occurs despite medical therapy or as a means of collecting cultures for definitive diagnosis. There are no good studies comparing surgery to medical therapy. It thus seems reasonable to recommend an empirical course of medical therapy after appropriate cultures have been obtained, reserving surgical debridement for those cases which fail to respond. It should be noted that some of these infections remit spontaneously and seem to smolder slowly for months before finally "burning out."

Prevention

Preventive measures are certainly important in decreasing the incidence of *M marinum* infections and other saltwater-acquired infections. Experienced watermen in our area routinely wear thick gloves to protect their hands while working with crab or fish. If a saltwater laceration occurs, meticulous wound care, including thorough irrigation, should be employed. These wounds should be left open when possible. Certain wounds, perhaps those that are severe or are associated with multiple punctures or bites from marine animals, may benefit from a brief course (3 days) of a tetracycline antibiotic.

Conclusion

We have presented nine cases of *Mycobacterium marinum* infection and reviewed the relatively scanty literature on this infection. The clinicians in our Chesapeake Bay community have developed a high index of suspicion for this disease, secondary to its occasional occurrence in watermen and fishermen in our area. We are certain there are many other cases that were treated early in an office setting and did not require hospitalization or surgery, and thus did not come to our attention. Early diagnosis based on consideration of this organism in the differential diagnosis of a water-acquired cellulitis holds the key to successful management. Urban physicians should keep the possibility of this infection in mind in their patients returning from fishing vacations and other aquatic activities.

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Crohn's Disease Presenting as Pelvic Mass: Case Report

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THIS is the report of a patient presenting with a right adnexal mass initially thought to be of gynecological etiology. However, preoperative radiographic evaluation led to a tentative diagnosis of Crohn's disease, despite the absence of gastrointestinal symptomatology, and that diagnosis was confirmed at laparotomy. Although this presentation is atypical, similar cases of granulomatous oophoritis have been reported in the recent literature.[1–7]

Case Report

A 39-year-old G4 P2 AB2 white female was referred for evaluation of a large pelvic mass and a history of three weeks of pelvic pain, fever, malaise and night sweats. The patient had no symptomatology suggestive of gastrointestinal disease or urinary tract involvement. Her past medical history was significant for a prior left oophorectomy for endometriosis, bilateral tubal ligation and an appendectomy. Initial physical examination revealed an apparently healthy middle-aged white female in no apparent distress. She was afebrile and the examination of her abdomen revealed no peritoneal signs. The pelvic exam did confirm a large 10×10 cm fixed mass slightly to the right of midline and occupying the entire cul-de-sac space. The mass was slightly tender and was fluctuant. Rectal examination confirmed the adnexal findings and the hematest of the stool was noted to be positive. An ultrasound examination of the pelvis shortly prior to admission confirmed the presence of the mass.

On admission the patient was noted to have an elevated sedimentation rate of 52 ml/hr with a white count of 6,300, normal differential and a hemoglobin of 11.9 gram/% and a hematocrit of 36%. Cultures of blood, urine and endocervix were later to report no growth. A tentative diagnosis of right tubo-ovarian abscess was made and the patient was placed on intravenous antibiotics. A preoperative evaluation consisted of a CT scan, barium enema, intravenous pyelogram, GI series and colonoscopy. In addition to confirming the presence of a complex right adnexal mass, the barium enema and GI series strongly suggested the presence of Crohn's disease with the typical radiographic appearance of terminal ileitis.

Preoperatively the patient remained afebrile and continued to have stable white blood cell counts with a persistently elevated sedimentation rate. She underwent a 3-day bowel prep prior to surgical exploration of the abdomen through a large midline incision. At laparotomy an enlarged edematous infarcted right ovary with evidence of suppurative oopheritis was noted. The adnexal involvement was secondary to a fistulous tract arising from a perforation of the cecum at the sight of a previous appendectomy procedure. The fistulous tract was lined with noncaseating granulomas containing typical multinucleated giant cells of Langerhans (Figs. 1A and 1B). The left ovary was

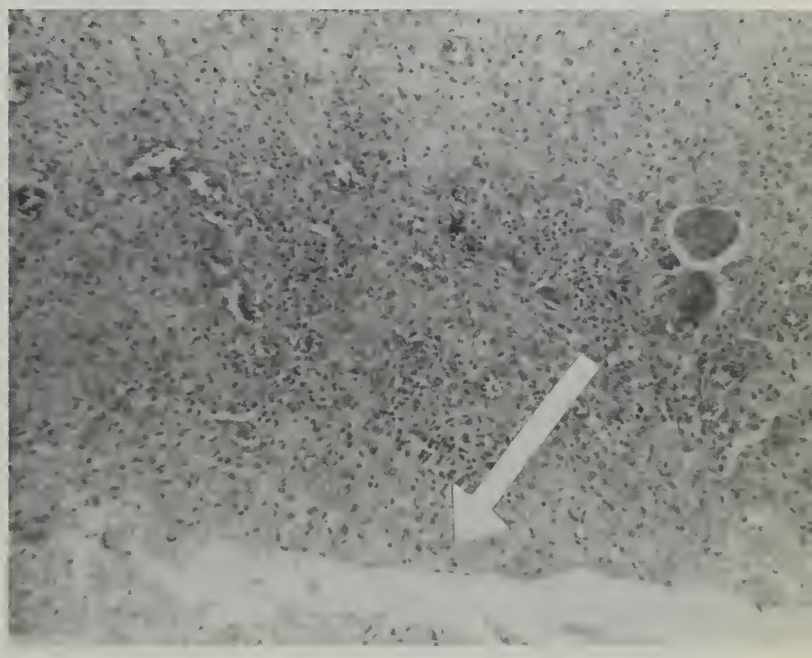

Figure 1A. Microscopic slide of fistula tract in cecum with noncaseating granuloma and multinucleated giant cells lining the tract. Arrow marks site of fistula.

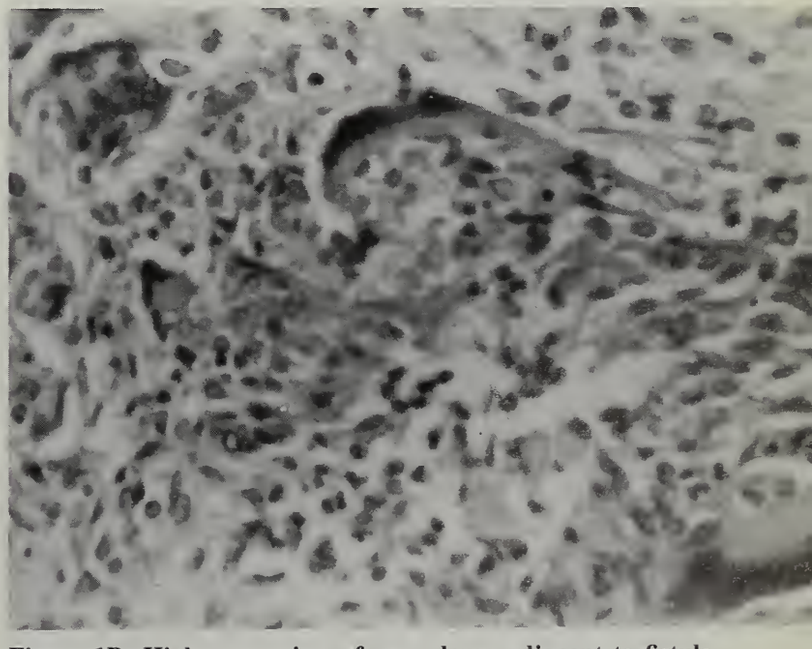

Figure 1B. Highpower view of granuloma adjacent to fistula tract in Figure 1A (×400).

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surgically absent and the left fallopian tube appeared to be involved with a pyosalpinx. After lysis of adhesions and restoration of anatomy, a total abdominal hysterectomy, bilateral salpingectomy and right oophorectomy was performed. The use of uretal stents greatly facilitated the dissection. In addition to this a right hemicolectomy and distal ileal resection was performed by the general surgeon. Closure was achieved with a primary anastomosis.

Postoperatively the patient did remarkably well and was on IV antibiotics for approximately 10 days. Throughout her hospital stay the patient remained afebrile and at the time of discharge had normal bowel and bladder functions. Her discharge hemoglobin was 10.9 grams% with a hematocrit of 33.8% and a white cell count was 6,400. Cultures of purulent material at the time of laparotomy later grew out *E coli* and *Candida albicans*.

Pathological examination of the tissue removed at the time of laparotomy showed a perforated area on the posterior aspect of the cecum. The wall of the perforation was heavily infiltrated by neutrophils and macrophages, scattered multinucleated cells and a few granulomas (Fig. 2). The wall of the ileum showed thickening with fibrosis and many lymphoid follicles with occasional epithelioid granulomas. The right ovary was 5×5×4.5 cm tan, reddish infarcted mass with some cortical multinucleated cells. The fimbria of the right tube was infarcted and the left tube showed acute pyosalpinx and endometriosis. The pathologic diagnosis of the right colon and distal ileum was Crohn's disease with perforation of the cecum.

Discussion

Involvement of the ovary with Crohn's Disease is rare, with the diagnosis seldom suspected preoperatively. If not for the fortuitous radiographic findings involving the distal ileum at the time of the barium enema, the diagnosis of Crohn's disease would not have been seriously considered preoperatively in our patient. In a remarkably similar case reported in 1988, Brady et al expected a tubal ovarian abscess preoperatively with operative findings consistent with terminal ileitis and fistulous involvement of the right adnexa. Pathological examination of resected tissue revealed Crohn's disease.[1] A case presented by Brooks and Wheeler in 1977 involved a woman with known long-standing granulomatous disease of the bowel who had left adnexal involvement via fistulous tracts; it is apparent from this case that both left and right adnexa can be involved secondarily to Crohn's disease.[2] Granulomas of the left adnexa may possibly be due to diseases other than Crohn's, as suggested by a case reported in 1984 by Benirschke and Bonin.[3]

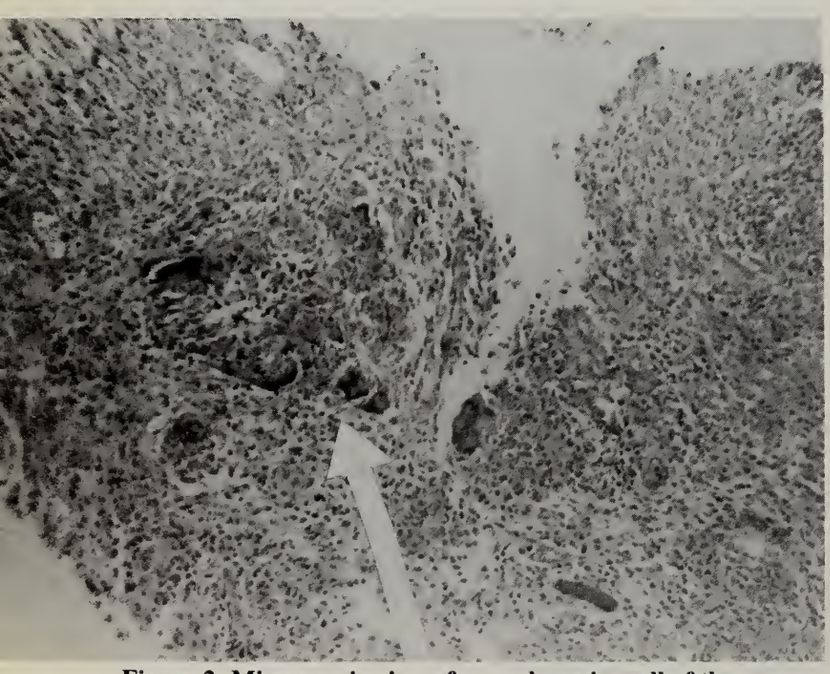

Figure 2. Microscopic view of granuloma in wall of the cecum.

It appears that a common denominator in most of the cases reported is primary granulomatous disease of the bowel with secondary involvement of either the right or left adnexa by way of a fistulous tract.[1,2,4–7] It is unusual that in our case the diagnosis of Crohn's disease was entertained preoperatively based upon radiographic studies routinely ordered for the workup of a pelvic mass. Crohn's disease is rarely encountered by a gynecologic surgeon and when it is encountered it is usually unexpected. It occurs more frequently in young adults and is usually associated with diarrhea, weight loss and abdominal pain.[8]

Conclusion

Primary gastrointestinal disease should be considered in all cases of unilateral adnexal disease. As this case demonstrates, the presence of a primary bowel disease should be suspected despite absence of gastrointestinal symptomatology.

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Birth-Injured Infants: Legal Definitions, Claims Frequency in Virginia

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SINCE the early 1980s state legislatures have attempted different approaches to tort reform that would eliminate crises of availability and affordability of medical malpractice insurance. In 1987, when Virginia faced such a crisis for obstetric malpractice insurance, the legislature broke new ground by passing the Birth-Related Neurological Injury Compensation Act. The state had previously enacted medical review panel and payment limitation legislation, but these actions did not stem the rate of claims or payouts for obstetric claims for birth injured infants.[1] Thus a new approach to remove the cases from the tort system yet provide for the extensive care often necessitated by severe neurologic birth injuries seemed a prudent alternative. The Act created a program for neurologically injured infants similar to that of the Workman's Compensation Act. Lack of information about the incidence of such cases and expenses involved, however, led the legislators to define entry criteria for the fund that were purposely restrictive. Otherwise, if the compensation fund could not support the claims from its inception, the approach was doomed to failure.

In the two years since its passage, the Injured Infant Act has been criticized for its narrow definition, and 18 months after the Act's fund had been operating, no claims for entry had been made. A retrospective two-year study of hospital records found children who met the Act's definition of severe neurologic injury were likely to have died in infancy, been premature, or the product of a complicated pregnancy likely to contribute to a poor outcome.[2] The authors questioned whether such children represented the majority of claims cases handled through the tort system. If the children who sue for damages differed markedly from those found to meet the definition, the ability of the Act to preempt litigation would be weak. To clarify the severity of disability and incidence of such claims, a retrospective study of open and closed malpractice cases was undertaken.

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Materials and Methods

Birth injury claims filed between January 1, 1980, and December 31, 1988, were requested from medical malpractice insurers operating in the state. This included insurers who had left the state but were insurers of record in the earlier years. The list provided by the Medical Society of Virginia's Task Force on the Injured Infant Act was verified with the State's Bureau of Insurance. The Bureau could confirm the list from 1984 to the present. Prior to 1984 no records were kept. The five firms contacted had at least 1% of the market share and reported losses of 300,000 or more for any year since 1984.

All physician liability carriers contacted agreed to participate in the study and allow review of open and closed claims. The five insurers participating in the study represented 94% of the market share. The remaining 6% of the market was shared among 63 companies. From their management information systems lists of obstetric claims were complied and records retrieved from claims handlers. The insurers gave the research team access to their files on their premises.

The records were abstracted to identify infants fitting the Act's definition and the three proposed definitions tested in the previous study (Fig. 1).[2]

To characterize the infants and gain insight to predisposing or accompanying events associated with severe neurologic damage, the following information was collected on each infant: Apgar score, sex, survival, diagnoses, history of obstetric or delivery complications, findings on admission, developmental level and handicaps, age at time of claim and age at settlement.

Although claims are registered by physicians, the unit of analysis for this study was individual claimants. Cases involving more that one company and/or more than one physician or a physician and a hospital were combined to represent one case. Claims were also reduced by eliminating claimants who did not fit the basic eligibility criteria in the definitions. This included children with congenital anomalies and genetic defects, children with learning disorders, and stillbirths.

Results

In the 9-year period studied, 78 infants were identified who would meet at least one of the definitions. Of the 78 cases, 51 are closed and 27 are open as of July 1, 1989. Of the 51 closed claims, 36 went to settlement and 15 were abandoned by the claimant. Year of occurrence and frequency are shown in Table 1. The children's birth years ranged from 1978 to 1988. Incidence of injured infants per year by raw number is so low that the rate of severely injured infant claims per thousand births is too small to be meaningful. As can

be seen from the table, these cases occur very rarely when compared to the total live births for the state over the ten-year period. Although the birth rate in the state is rising, the claims do not appear to be increasing with the birth rate either for term or preterm infants. However, the impetus for the liability crisis can be seen from the frequency of reporting the claims by year: 55% of the cases were filed between January 1985 and December 1987, whereas prior to 1985, relatively few cases were filed. In 1988, when the Injured Infant Act went into effect, the rate of new claims dropped by two-thirds and ended a three-year climb in the number of claims reported.

Fig. 1. Enacted, Proposed Definitions of Birth-Related Neurological Injury.

VIRGINIA DEFINITION

"Birth-related neurological injury" means injury to the brain or spinal cord of an infant caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital, which renders the infant permanently nonambulatory, asphasic, incontinent, and in need of assistance in all phases of daily living, This definition shall apply in live births only and shall not include disability or death caused by genetic or congenital abnormality.

FLORIDA DEFINITION

"Birth-related neurological injury" means injury to the brain or spinal cord of an infant of term gestation caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

MEDICAL SOCIETY OF VIRGINIA ALTERNATIVE DEFINITION I

"Birth-related neurological injury" means injury to the brain, spinal cord, or peripheral nervous system of an infant caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital, which renders the infant permanently or substantially mentally or physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

MEDICAL SOCIETY OF VIRGINIA ALTERNATIVE DEFINITION II

"Birth-related neurological injury" means injury to the brain or spinal cord of an infant caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

Of the 78 infants, 25 died prior to a claim being made. Thus death occurred approximately one-third of the time. Seventy-six percent of the deaths occurred in term births. The median age at the time of death was one month or younger. The range in age between birth and time of death varied from several hours to 48 months. Seventy-five percent of the infants died within 4.25 months of birth.

The age of the children at the time the claim was made varied from one month to 9.25 years with a mean of 24.7 months. The median age was younger at 19 months. Survival of the infant influences the age at which a claim is made. For the deceased infants, claims were made on the average of 9.3 months from birth and approximately nine months after their deaths. For surviving children, the median age for making a claim was 23.5 months.

For the 20 settled claims of living children, the average age of the children when the case was closed was 6 years. It took between 24 and 99 months to settle the claims. The average time to close a case was three years.

Unlike the earlier study, the majority of children were term deliveries (64.9%). Prenatal or delivery complications occurred in 93.2% of the cases. The most frequent diagnoses were prematurity (29.5%), placental problems (abruptio, previa, infarction) (17.9%), and breech presentation (16.7%). The median Apgar score at one minute was 2; median Apgar score at 5 minutes was 4. The mean birth weight for the group was 3064 grams with a range from 420 grams to 5505 grams.

Twenty-three percent of the children were surgical deliveries. The most common legal reason for the claim was "failure to do a timely cesarean delivery."

When categorized by disability, 50 children fit the Virginia definition, 39 fit the Florida definition, 78 fit the Medical Society of Virginia Alternative Definition I (MSVI), and 61 fit the (MSVII) category.

Descriptive statistics by category are shown in Table 2. For the Virginia definition, 24 deaths in the group represent 48% of the sample. Survival rates were are higher for the other categories of injury. The median age when a claim was made does not differ greatly by category. Median age for settlement does. This is related to the degrees of impairment found in the MSVI category. Children with plexus injuries or physical injury with no mental impairment settled their claims earlier than those with mental and physical impairment.

Any attempt to revise the definition of disability to be less exclusive raises questions of the effect of

Table 1. Incidence in Virginia of Injured Infants and Claims Reported Compared to Live Births Above and Below 2500 grams, 1978–1987.*

Year	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
Total births	73349	76899	78423	79278	81098	80779	82662	85984	87125	90314	–	–
Over 2500 gm	67852	70987	72421	73330	75014	74745	76553	79840	80840	83903	–	–
Under 2500 gm	5399	5814	5916	5851	5944	5905	6036	6070	6207	6355	–	–
Unknown	98	98	86	97	140	129	73	74	78	56	–	–
Total injured infants	2	2	10	10	9	5	9	13	9	8	1	–
Over 2500 gm	2	2	9	4	7	2	5	8	8	7	1	–
Under 2500 gm	0	0	1	6	2	3	4	3	1	1	0	–
Claims reported	0	0	1	1	4	7	4	13	12	17	6	2

* Statistics for 1988, 1989 not available as of July 1989.

Table 2. Descriptive Statistics by Category of Injury.

Category	VA	FLA	MSVI	MSVII
Total no. each category	50	39	78	61
Death	48.0%	35.9%	32.1%	39.3%
Median age when claim made (mons)	25	22	23.5	24
Premature	29.4%	0%	29.5%	27.8%
Median age when claim closed (mons)	74.5	74.5	57	73

Table 3. Type of Injury by Category of Injury.

	VA N = 50 (%)	FLA N = 39 (%)	MSVI N = 78 (%)	MSVII N = 61 (%)
Plexus injury	0 (0.00)	0 (0.00)	5 (6.41)	0 (0.00)
Physical injury/ no mental impairment	9 (0.00)	0 (0.00)	8 (10.26)	0 (0.00)
Mental injury/ no physical impairment	0 (0.00)	0 (0.00)	4 (5.13)	0 (0.00)
Physical and mental impairment	50 (100.00)	39 (100.00)	61 (78.21)	61 (100.00)

different definitions on number of claims because frequency of claims has an impact on the solvency of the fund. Table 3 shows the distribution for types of claims allowed by the four categories. Substantial physical and mental disability contributes most to the number of children in each of the categories. Opening the category to children having either a permanent disabling plexus injury or severe physical disabilities or severe mental disabilities added an additional 17 (22%) children to the group of children who were severely mentally and physically handicapped. Overall, prematurity had a greater impact on total number (30%) of children than expanding the definition of disability.

Discussion

On the surface it appears that the Act has had an initial effect of dampening the number of claims. Although children entering the tort system in 1988 were likely born in earlier years, the effect of the Act may be to discourage suits because it may be perceived by plaintiffs' attorneys that the climate for large settlements is changing. However, the effect may be the result of fewer children born who meet the criteria and/or claims being withheld from the tort system until the issues of the Act's constitutionality and definition are settled.[3]

The Injured Infant Act reduces the amount paid per claim by eliminating the contingency fee arrangements. Such arrangements provide an economic incentive to file suit.[4] In addition, assistance to families is available much sooner than the tort system allows. Instead of waiting on an average of six years to receive assistance, as was the case with the claims settled in the last ten years, help is available to qualifying infants from birth.

Most importantly, the Act acknowledges the complexities as well as the difficulties of birthing and removes destructive "blaming" that occurs with these claims. The three most common obstetric complications noted in these cases are life-threatening to both mother and infant and those over which a physician has little control; without the assistance of health care providers, mortality and morbidity for both mother and infant are high.

However, for the program to be successful it must cover those children likely to sue. From this review of claims it appears that the definition is restrictive. Almost half of the children fitting the Virginia definition are deceased. Broadening the definition did increase the number of claims by 50%. However, even when the additional children were added by relaxing the disability criteria, the total number of children remained low, considering that the reported incidence of severe cerebral palsy is 2 to 5 per 1000 live births.[3] The incidence of claims per year was too few to report a meaningful statistic by 1000 live births. Also, the Act's funding levels are based on an estimated 15 years of survival per child; thus a large number of deaths greatly lessens the fund's actual payout.

While exanding the definition appears a reasonable option, given the findings of this study and its predecessor, the lack of specificity in the terms "substantial physical *and* mental impairment" or "substantial physical *or* mental impairment" may prove problematic. If entry to the fund is to be unbiased, then a relaxed definition, but one with explicit constraints or standards of mental and/or physical functioning, may be the prudent choice to eliminate gaming by all parties.

Summary

This review of claims supports the findings of an

earlier study on the incidence of injuries defined by the Injured Infant Act. Assignment of children to Virginia's definition of injury was associated with death in the neonatal period and preexisting maternal conditions likely to contribute to a poor outcome. Expanding the definition was more likely to capture living children needing substantial assistance in all phases of daily living. Futher refinement of the definition appears advisable to assure that those receiving support meet the Act's intent.

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BOOKS

Damning the Innocent, by Pierre Darmon. Translated from the French by Paul Keegan. Viking-Penguin, Inc., 1986, 234 pp, $18.95.

Cognition or procedure—which is more valuable? Darmon's *Damning the Innocent* gives us an inkling of the relative value of thinking and of doing, revealed by the trials for impotence during the late Renaissance and Age of Reason periods in Europe.

The Church Fathers, St. Paul and St. Augustine, considered celibacy the highest state of grace, because sex caused the Fall and continuing this activity perpetuated this sinful state. Since all men and women do not have the inner strength to remain celibate, the Church accepted lawful marriage as an outlet for this human frailty, but marriage was lawful only if both bodies and souls coupled. A marriage in which the bodies did not unite defiled the sacrament and was cause for annulment.

Divorce was practically impossible, and there were few reasons for annulment. But the trial lawyers saw an opening. If either of the marital partners was impotent, the marriage should be annulled, since clearly there could be no union of bodies. Souls perhaps, bodies no. Over time, a frenzy of legal activity dwarfing the medical malpractice lottery of today arose in Europe and continued until the 19th century. And no wonder. The trial lawyers prospered, the plaintiff lawyers prospered, and our medical forebearers did not do badly either. Some thought the process was being abused for the convenience of the wealthy, the enrichment of doctors and lawyers, and the titillation of the celibate clergy.

Though as many as thirty points were weighed to determine guilt or innocence, the smoking gun was usually found from physical examination. But who could sort out the evidence and identify the smoking gun? A controversy raged. It was agreed the surgeons were superior in physical examinations, but they could only report what they saw. They were not trained to think. Why, even the ecclesiastic judges could see and report as much as the surgeons, were modesty to permit. The physician, however, was trained to explore the innermost parts of nature and to deduce beyond what the eyes could see. Distinctly superior, they claimed, to those who used the cautery and knife.

It is not stated, but I imagine that to resolve this controversy a study commission was formed of lawyers, doctors, and secular and ecclesiastical judges, because a political compromise was reached: Both a surgeon and a physician had to be present at the examination of the defendant in a trial for impotency. Both were entitled to fees set by the court.

One type of physical examination was conclusive. This was termed "Trial by Congress", and in this the couple was required to perform under the witnessing eyes of experts—in one instance, five physicians, five surgeons and five matrons. If the accused failed, he was given another chance in another setting. Reminiscent of the malpractice scene today, the lawyers extended the matter beyond annulment to lineage, inheritance, division of property and child custody—though to be fair, the lawyers were responding to the demands of society. Public outrage and permitting male doctors to practice obstetrics were instrumental in the disappearance of the societal phenomenon.

But back to the question: Which is more valuable, cognition or procedure? In the Hubigneau trial of 1700, the court awarded the physician twelve livres and the surgeon nine livres. Blue Cross and Blue Shield, take note!

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VIRGINIA MEDICAL
EDITORIAL

Biomedical Ethics

How are decisions made to start or stop life-sustaining technologies? From such questions arise the most frequent ethical problems in clinical and long-term care as practiced in the United States.

Elsewhere in this issue, Dr. John Fletcher, noted bioethicist, presents five maxims fitting five common dilemmas to help guide the physician in such circumstances. By his definition, a maxim is a short summary of ethical guidelines entailing the best approach to specific types of cases, each presenting a particular ethical problem. As such, a maxim serves as a standard of care for an optimal approach to a particular ethical problem.

All those engaged in the practice of medicine will at some time be faced with one or more problems similar to those discussed by Dr. Fletcher. It is reassuring to know that one's own ethical problems are not unique and that helpful counsel is available.

E.L.K. Jr.

Contributors

Physicians have the reputation of being poor contributors to charitable causes. In monetary matters, this reputation is justified. Doctors in the past have contributed so much free medical care that they have not felt motivated to make additional monetary contributions. But times have changed. While the medically indigent still exist, third-party payers have sharply reduced the number so affected.

This is what makes the article in a recent issue of the Richmond Academy of Medicine's newsletter, *RAMifications*, so interesting and important. Physicians are not coasting. Dr. Cullen Rivers is interested in the problems of the inner city and has worked hard in that area; he is involved in the Cross-Over Ministry and presently is co-medical director of a free medical clinic. Dr. George Burke is part of another local ministry—the Richmond AIDS ministry; as such he is medical advisor to the Board. Dr. Stephen Powelson is a "loyal volunteer" at the Richmond High Blood Pressure Center.

An article in the *Manassas Journal-Messenger* tells a story about Dr. Warren Klam. He is an Episcopal priest as well as a pediatrician, trained in adolescent medicine, and currently works part-time as a youth consultant at a church in Arlington, where he fills in for the rector.

There must be many others who are similarly involved. Indeed, it is likely that most physicians are contributors. We just don't hear about them.

E.L.K., Jr.

Too Fat

Overeating and obesity are out of style while anorexia and bulimia are in style. The morbidly thin and the compulsively retching receive compassion, sympathetic publicity and even notoriety.

The compulsively overeating receive little compassion and a lot of unsympathetic publicity because we believe that fat people have a deficiency of character and will power, that they contribute willfully to their incipient health problems, and that they deliberately refuse to comply with our expected image of them.

Little wonder that the jolly fat person is an endangered species.

Recently at a shopping center my concerns for the mental health of the obese were allayed. When I first saw her, she was walking across the parking lot with an air of self confidence. She was very short and very much overweight, about 5 × 4, I estimated. She had difficulties climbing into her small compact car and also getting settled behind the steering wheel. But she drove off in grand style, proudly displaying her customized license plate, "2FA T4U."

I have never met her, but I like her.

H. S. Campell, MD

HISTORICAL NOTES

George Tebault: Renaissance Man

In the years before the Civil War, the South was criticized for its lack of scientific, educational, industrial and cultural achievements. Northerners said the institution of slavery kept the South a backward agricultural area while the rest of the country was making rapid leaps forward.

Some of the criticism was well-founded, but the situation wasn't as dismal as many Northerners made it appear. There were some Southerners who were making strides in areas such as medicine, agriculture and technology. One of them was Dr. Alfred George Tebault, who spent most of his adult life near London Bridge in Princess Anne County (now Virginia Beach). He presents a fine portrait of a progressive 19th century Southerner.

Born in Charleston, South Carolina, and educated at South Carolina Medical College, Dr. Tebault came to Norfolk to help with an outbreak of Asiatic cholera. After marrying a Princess Anne County girl, Mary Cornick, he settled at London Bridge, where he began his medical practice.

Dr. Tebault was a slim, mustached gentleman with the look of a dreamer in his eyes. Modest about his accomplishments, he was an enchanting conversationalist. He and his family lived a good life for that time, owning several acres of land, five to ten slaves and quite a bit of personal property.

In that era, there was a great deal of debate about the medical difference between black and white people. Dr. Tebault made a four-year study of the issue and the results were published in the *American Journal of Medical Sciences*.

"The blacks are by far less liable to [yellow] fever, both intermittent and remittent, than the whites," he wrote, "and when they are attacked their cases are generally milder and very easily relieved."

His statistics showed that in the first year of the study there was a ratio of 26 blacks to 100 whites who caught the disease. The second year, the ratio was 15 blacks to 100 whites; the third year, 40 to 100, and the fourth year, 33 to 100.

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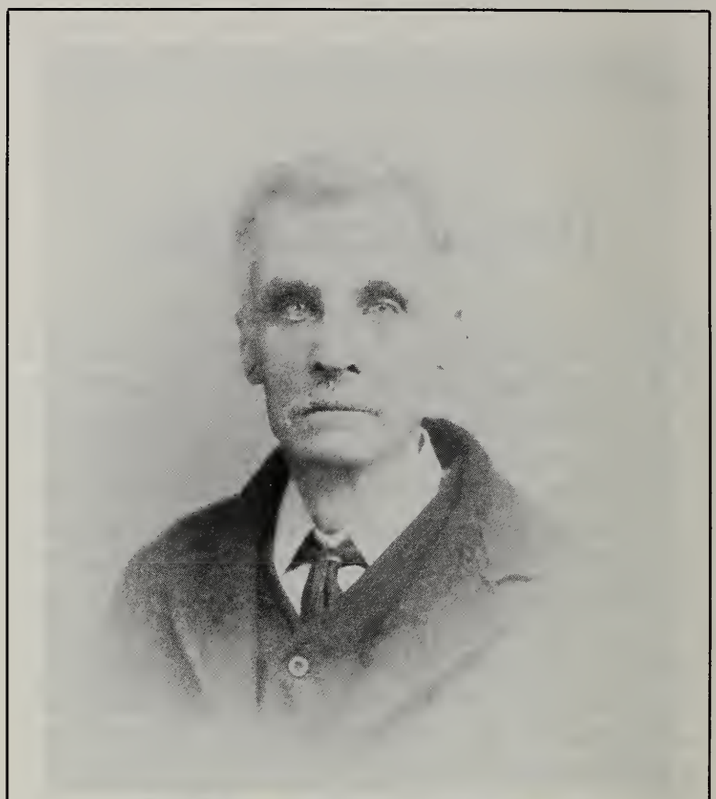

Dr. Tebault in 1874, when he was President of The Medical Society of Virginia

Dr. Tebault also made extensive notes on a scarlet fever outbreak among the slaves in his area. Both he and his 2-year-old daughter contracted the disease in the course of his study. He had an article on diseases of the spleen published in the *American Journal of Medical Sciences*, and another on malaria published in the VIRGINIA MEDICAL MONTHLY.

His friend, Dr. L. B. Anderson, writing about him in the *American Doctor*, said, "I know of no medical man whose fund of information is so large, so varied and so accurate."

Dr. Tebault wasn't interested only in medicine. Somewhat of a Renaissance man, he took a couple of years off from his medical practice in the early 1840s to travel in the West. Obviously his imagination was fired by the opening up of those vast areas.

Back home in Princess Anne County, he risked his life to treat Norfolkians who had succumbed to the dread yellow fever in the outbreak in the 1850s. He served in the Virginia House of Delegates in 1857-1858 and went on to become President of The Medical

ia. He became well-known as a lecturer on government, medicine and law.

Dr. Tebault had a secret side also. He had an interest in history and was the author of a book, *The Chronicles of Florida*, about the Spanish adventurers in Florida in the 1700s. At that time Northern literature was flourishing, but it was still considered unmanly to be a writer in the South. Dr. Tebault chose to write under the pen name of Athanase. Athanase probably alludes to either Athenaesus, an early Greek writer, or Saint Athanasius, a Doctor of the orthodox church and patriarch of Alexandria.

Very typical of the times, Dr. Tebault was a devout Christian. His friend Dr. Anderson ended his article on the doctor this way:

. . . He loves to dwell upon the past and contemplate the developments of the present, but most of all he loves to think of the home of the blest, in the land beyond the river. He is quietly and calmly awaiting the summons to close up his earthly mission and repair to his mansion in the skies. When he is gone another name will adorn the roll of the grand old Virginia doctors whose fame, had it equalled their merits, would have adorned the brightest page of medical history.

Dr. Tebault repaired to his mansion in the skies in 1895, proof that not all Southerners were backward and lazy.

MARY REID BARROW

Editors Note: The *American Journal of Science*, first published in 1818, is still issued monthly by the Kline Geology Laboratory of Yale University. *American Doctor* was published in Richmond from 1891-1894.

Correction

In an editorial in the August issue (VMAPP. Va Med 1989; 116:324) the statement was made that ". . . there are still those who cannot afford the difference between the Medicare assigned rate and the physician's usual and customary charge . . ." This statement was erroneous. No Medicare recipient is ever liable for anything more than 20% of the Medicare assigned rate for any physician. The Editors regret this error.

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VIRGINIA MEDICAL OBITUARY

• **James F. Blades, MD,** retired Richmond surgeon; Yale University School of Medicine, 1934; age 81; died August 21, 1989. He was in private practice for 41 years and was an assistant professor of clinical surgery at the Medical College of Virginia/VCU.

• **Howe Reese Coleman, MD,** long-time Lexington ophthalmologist who retired two years ago; University of Virginia School of Medicine, 1929; age 84; died May 24, 1989. A brother, Custis L. Coleman, MD, Richmond, survives him.

• **William A. Davis, MD,** St. Paul, Virginia; University of Tennessee School of Medicine, 1945; age 71; died September 12, 1989. He practiced medicine in St. Paul and Dante for 40 years.

• **Louis Farano III, MD,** Virginia Beach; Facoltà di Medicina e Chirurgia, Università di Bologna, Italy; age 66; died July 17, 1989. He was a general practitioner.

• **Burton Eugene Field, MD,** Dillwyn general practitioner; Tulane University School of Medicine, 1937; age 77; died January 27, 1988.

• **Nicholas P. Hranowsky, MD,** retired Richmond anesthesiologist; Ludwig Maximillian University, Munich, Germany, 1954; age 66; died August 14, 1989.

• **T. Ross Kazakis, MD,** Virginia Beach; Faculty of Medicine, Aristopelian University of Thessaloniki, Greece; age 63; died August 11, 1989. His specialty was obstetrics/gynecology.

• **David Charles O'Brien, MD,** Portsmouth; Georgetown University School of Medicine, 1943; age 72; died July 17, 1989. Dr. O'Brien retired in 1983 after 37 years as a family practitioner.

• **Peter N. Pastore, MD,** Richmond; Medical College of Virginia, 1934; age 81; died September 16, 1989. On his retirement in 1976 Dr. Pastore was named professor emeritus in otolaryngology at MCV.

• **William Clarke Pole, MD,** retired Norfolk orthopedic surgeon; University of Virginia School of Medicine, 1952; age 63; died May 9, 1989.

• **Joseph A. Robinson, MD,** long-time family physician in Richlands; Medical College of Virginia, 1933; age 82; died June 23, 1989.

• **Frank B. Sloop, Jr., MD,** Charlottesville pathologist; University of North Carolina, 1973; 42 years old; died August 10, 1989.

• **Edgar Newman Weaver, MD,** retired Roanoke neurosurgeon; University of Virginia School of Medicine, 1943; age 71; died August 14, 1989. He was a past president of the University of Virginia Medical School Foundation. A son, Edgar N. Weaver, Jr., MD, Roanoke, survives him.

Memoir of J. A. Stephenson 1936-1989

By Richard C. Morris, MD

Dr. John Aldrich Stephenson, a highly respected pediatrician in Lynchburg, died suddenly on May 14, 1989.

A native of Chicago, Dr. Stephenson earned his medical degree from Case Western Reserve in 1961. He received his pediatric training at the University of North Carolina at Chapel Hill. John later served in the US Army as a research associate in the Virology Department at the Walter Reed Hospital Army Institute of Research from 1964 to 1969. He continued his research in Cooperstown, New York, at the Mary Imogene Bassett Hospital through 1970. After a brief practice in Atlanta, Georgia, he started a solo practice in Lynchburg in 1972. By 1983, John's solo practice had grown into a four-doctor office.

John was active in the community. In 1981 he served as president of the medical staff of Lynchburg General Hospital and Virginia Baptist Hospital. He was very concerned about substance abuse among our teenagers and was a popular community speaker. John was a strong supporter of Mothers Against Drunk Drivers (MADD) and served on the board of the Virginia Alcohol Safety Action Program (VASAP).

He is survived by his wife, Sue Honaker Stephenson, and two sons, Taft and Graham.

John's manner was one of quiet, wise leadership. He will be missed by all of us—his colleagues, his patients, the children and their parents, and the community at large.

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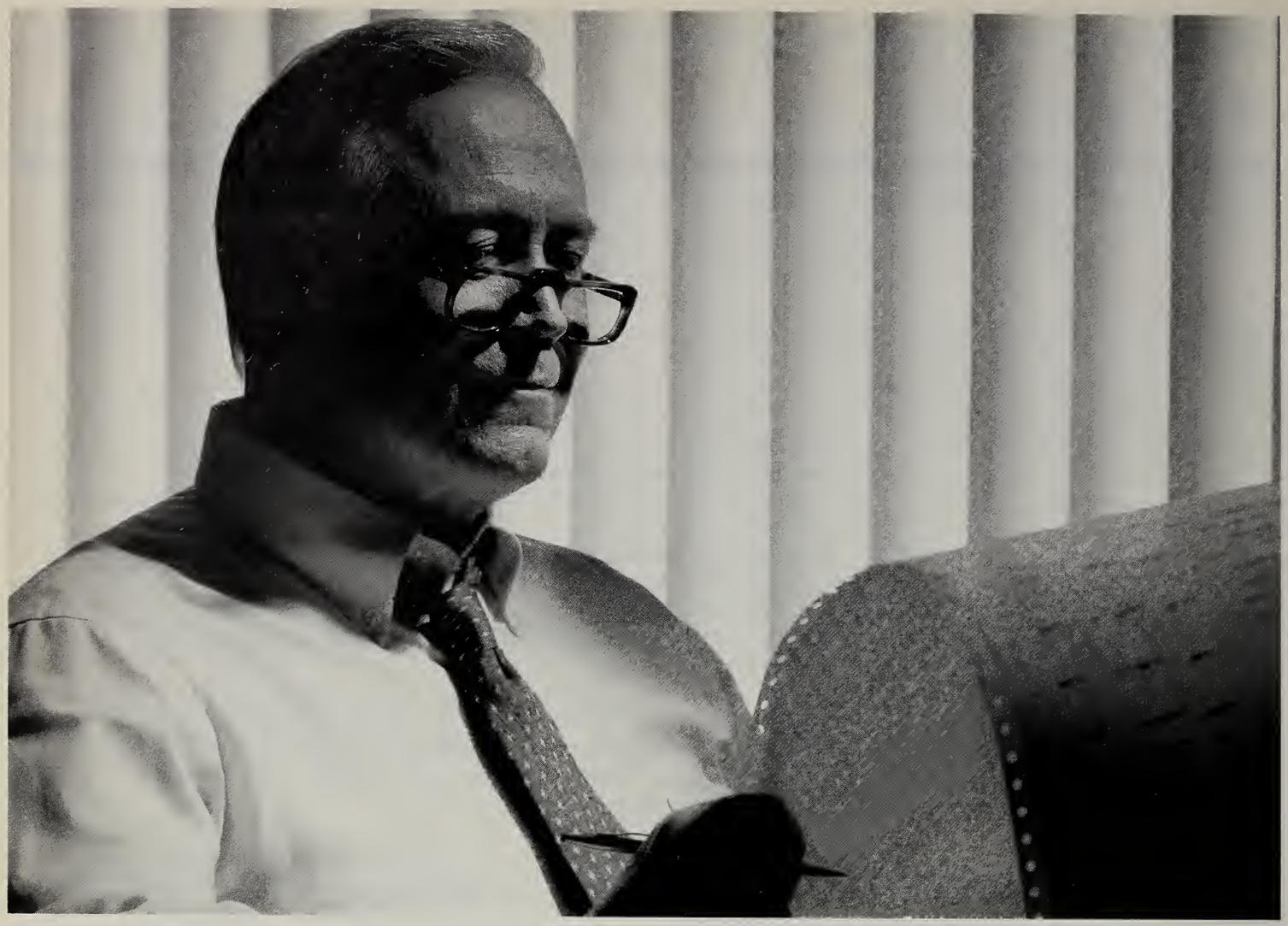

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meeting in Richmond during the second session of the House of Delegates. The decision to deunify was made not by the House, however, but by the membership. That was the course recommended by Reference Committee Three, which had considered 1) the Report of the Committee on Unification/Deunification, advocating reevaluation by the House of its unification decision; 2) a resolution from the Williamsburg-James City County Medical Society asking for repeal of unification; and 3) the Report of Council, calling for a vote of the membership, with proxy ballots as legal tender, on a resolution to deunify. The Council backed up its recommendation by citing the "tremendous loss in membership and income over the past four years of unification" and the overwhelmingly negative comments on unification written into the responses to the 1989 Physicians Opinion Survey (Va Med Oct 1989).

Testimony at Reference Committee Three's hearings had borne out and enlarged upon the councilors' concerns. Even Dr. William S. Hotchkiss, the most recent (1987-88) of Virginia's five AMA presidents, threw in the towel. He had regretfully concluded, he said, that the Society simply had to deunify, the issue had become too divisive. Meantime, it was bruited about the hallways that the proxy ballots sent out early in October on Council's authorization had brought in an overwhelmingly pro-repeal vote. By the time Chairman Carol Shapiro read out Reference Committee Three's recommendation, only one delegate rose with a caveat: Since unification was adopted by a vote of the House, he said, shouldn't the House make the decision on deunification? Swiftly rejecting this idea, the delegates adopted the recommended membership route.

Thereupon Speaker George Broman yielded the podium to Presiding Officer Tom Hulvey, who called to order a meeting of the membership and appointed election inspectors. Dr. Hulvey asked for the distribution of ballots to those who had not sent in proxies. As tellers moved about the room, a delegate asked for recognition. "This membership meeting and the proxy ballots--is this entirely legal?" he asked. Absolutely, Dr. Hulvey assured him; every step had Counsel Allen Goolsby's seal of approval. "May I change my proxy vote?" another delegate called out. Dr. Hulvey assured him he could, by filling out one of the ballots being circulated and noting on it that it replaced a proxy vote. The ballots were collected, the membership meeting was adjourned. The House of Delegates resumed its deliberations.

Half an hour later the inspectors came back with the count and Dr. Hulvey read out the figures. There was no response of any kind. The hall was silent, the delegates expressionless. They had seen a need to cut the cord and they had done it and that was that.

Va Med's January issue will carry a summary of all the House of Delegates' actions and pictures of the meeting. --A.G

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LETTERS

Questions use of new VHSL exam for Eastern Shore athletes

During the third week of school, I finally received my September 1989 issue of VIRGINIA MEDICAL, which contained the extensive article on the new Virginia High School League physical examination form.[1]

It is quite obvious, both from the form and the accompanying article, that the committee went to extensive lengths to try and account for all contingencies and to assure the safety of our students. However, the other fact that becomes clear is that the VHSL is anxiously trying to cover its medical-legal butt.

Once the VHSL establishes this extensive physical exam as the standard of care throughout the state, it becomes extremely difficult for any physician conducting the exam to then omit any part of the exam. In my opinion, to do so would be to practice medicine below the standard of care, thus exposing the examining physician to any accompanying liability.

The net result of this new, extensive form can be very devastating to the Eastern Shore of Virginia, which is among the poorest areas in the entire state. We have far too many youngsters who cannot afford a physical exam in the physician's office. Therefore, the physicians often donate and/or receive minimal compensation for organized exams conducted at the school. It is impossible for us to conduct the required extensive examination at the facilities that we have. The net result to the students is that those who can least afford private physical exams, which are probably those who most need the inducement of athletic participation to remain in school, are effectively blocked from participation. This would be, indeed, unfortunate! In the past, we have had several young people earn college educations through sports scholarships that they could, otherwise, never afford.

It seems to me that the purpose of the preparticipation exam is to conduct a screening exam to eliminate preventable injuries. It is not the purpose of the preparticipation physical exam to guarantee the health of any student, nor to guarantee that that child will not be hurt while playing sports. Participation in any sport of necessity involves risk.

I would appreciate any input into our dilemma of how to best serve our young people, both medically and also in view of the financial status. I know that I, for one, am unwilling to participate in the mass physical exams unless my standards of quality have been met. This has been obtainable in the past; it cannot be obtained with the present form and requirements.

My next question is: What new requirements will be placed upon us in the next five years—a full-body CT scan?

Carol L. Koenig, MD

Onley Medical Center
PO Box 86, Onley VA 23418

1. Perriello VAjr et al. New medical standards for Virginia's high school athletes. Va Med 1989;116:359-367

The authors reply: Dr. Koenig is correct that we have attempted to "assure the safety of our students" and that the "purpose of the preparticipation exam is to eliminate preventable injuries." The new form was initiated by the medical community, not the VHSL, and reflects the quality of care described in the recent sports medicine literature. As we pointed out in our article, the exam is practical to complete in 15 minutes when performed in an individual physician format and can be done in less than that when performed in the station approach used by 80% of Virginia's schools. It is pertinent to note that Dr. James McDowell and Dr. Paul Brown in Smyth County organized their community to provide for the students of their area an examination even more comprehensive than the one suggested by the new form.

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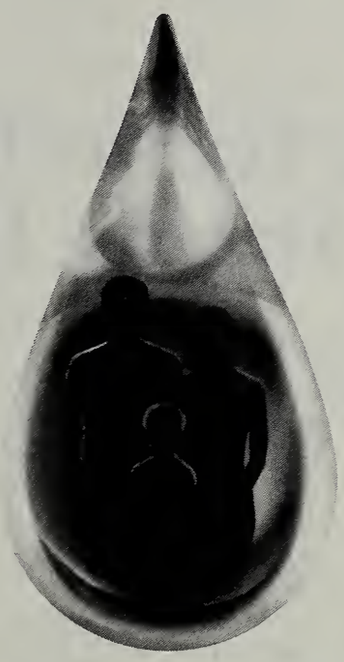

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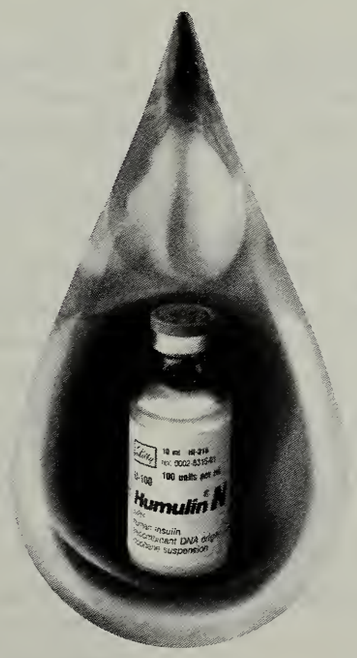

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Twenty-Five Years of Renal Trauma At a Teaching Hospital

Byron Osborne, MD, Kenneth Collins, MD, Frederick Klein, MD,
M. J. Vernon Smith, MD, and Warren W. Koontz, MD,
Richmond, Virginia

In a study of 535 patients with renal trauma admitted to the Medical College of Virginia Hospitals from 1962 to 1988, the authors found indications of a decrease in the rate of total nephrectomy in patients with blunt trauma, due in part to advances in diagnostic technology. In the cases of gunshot wounds, however, a persistently high rate of nephrectomy prevailed, reflecting, the authors believe, the proliferation of increasingly lethal weaponry.

SIGNIFICANT renal injury occurs in 8–10% of all cases of abdominal trauma. Associated abdominal injuries occur in approximately 80% of cases of penetrating trauma. However, with blunt trauma, associated injuries occur in approximately 20% of cases.[1,2] The incidence of associated injuries with blunt renal trauma rises as the severity of the injury increases. Although controversy remains with regard to the diagnostic evaluation and appropriate management of renal injuries, the trend today is for the more conservative and nonoperative management of selected injuries, and surgical exploration is reserved for the severely damaged kidneys from blunt trauma. There is a trend to use conservative nonoperative management of selected penetrating injuries. In order to see if today's approach to renal trauma has resulted in any significant difference in the outcome, the management of renal trauma at our institution was compared for the periods of 1962 to 1972 (Group I), 1972 to 1985 (Group II), and 1985 through February 1988 (Group III).

From the Department of Surgery, Division of Urology, Medical College of Virginia/Virginia Commonwealth University. Address correspondence to Dr. Koontz at Box 118, MCV Station, Richmond VA 23298.

Presented at the annual meeting of the Mid-Atlantic Section of the American Urological Association in Baltimore, Maryland, September 28–October 2, 1988.

Materials and Management

During the period 1962–1972, 195 patients (Group I) were treated for renal trauma. The data regarding this group has been previously reported[3] and is the basis with which some of the data obtained on 284 patients (Group II) from the period 1972–1985, and 92 patients (Group III) 1985–1988 were compared (Table 1). The data collected from Groups I, II and III includes methods of evaluation of the injury, type of injury and method of management. In addition, in Groups II and III the extent of injury was classified according to the following: 1) renal contusion or minor laceration (Class I), 2) cortico-medullary laceration with or without extravasation (Class II), and 3) shattered kidney or vascular injury (Class III).[4]

Results

The methods of evaluation of the injury are listed in

Table 1. In Groups I, II and III, an intravenous urogram was the initial evaluation study in most of our patients: 173 out of 195 patients in Group I, 233 out of 248 patients in Group II, and 71 patients out of 92 in Group III. A small number of patients were unstable in the emergency room and were taken to surgery without preoperative radiologic evaluation. This occurred in 22 patients in Group I, 14 in Group II and 6 in Group III.

The data also demonstrates the changes in technology. In Group I, a number of retrograde pyelograms were performed, plus a few arteriograms and renal scans. In Group II, arteriograms had become more popular and the use of computerized tomography had been introduced. In Group III, there was a reduction in the number of arteriograms performed but many more computerized tomographic procedures.

Table 1 also compares Groups I, II and III with the type of treatment. In Group I, those patients who had had blunt trauma, 17% of patients (27 of 163) underwent surgical exploration. Fourteen of these patients required a nephrectomy and 13 kidneys were repaired. In Group II, only 7% (13 of 183) required exploration, and in Group III, 5% (4 of 80) required exploration. The nephrectomy rate for Groups II and III decreased from 8.5% in Group I to 3.2% in Group II and 3% in Group III.

It would, therefore, appear that modern techniques of evaluation of these patients plus a more conservative approach resulted in fewer explorations and fewer nephrectomies.

Penetrating injuries, however, reveal another story. Of the 32 penetrating injuries in Group I, 88% required exploration and 43% (14) of these patients required a nephrectomy. Groups II and III showed no significant difference. Indeed, 90% of Group II and 83% of Group III patients underwent exploration. The nephrectomy rate was 39% in Group II and 33% in Group III. Table 2 divides the penetrating injuries in Groups II and III into gunshot wounds and knife wounds. Stab injuries or knife wounds of the kidney were small in number, but out of a total of nine cases, no nephrectomies were required, even though two-thirds of these patients were explored. Exploration was usually carried out because of a concern for associated intraabdominal injury from the stab wound. All nephrectomies in Groups II and III patients resulted from penetrating injury secondary to gunshot wounds.

Table 3 reveals the numbers of associated injuries in Group III patients. As has been shown in other studies, injuries of the colon, spleen, stomach, pancreas, liver and small bowel are prominent with penetrating injuries, whereas with blunt trauma, associated injuries of the head, chest and boney structures are more prominent.

Table 4 classifies the injuries in Groups II and III. Penetrating injuries resulted in a significant increase in the percent of Class II and Class III injuries than were seen with blunt trauma. There appeared to be no significant difference in Groups II and III, but with penetrating injuries, we can see that these injuries in Group III were of a higher class.

Table 1. Renal Trauma in 535 Patients at the Medical College of Virginia 1962–1988.

	Group I (1962–1972)	Group II (1973–1984)	Group III (1985–1988)
Total No. Patients	195	248	71
	Method of Evaluation		
Intravenous Urogram	173	233	71
Retrograde Pyelogram	19	0	0
Arteriogram	6	13	4
CT Scan	0	4	25
Renal Scan	5	0	1
No Study	22	14	6
	Type of Treatment		
Blunt Trauma	163	183	80
Surgical	27 (17%)	13 (7%)	4 (5%)
Nephrectomy	14 (8.5%)	6 (3.2%)	2 (3%)
Repair	13	7	2
Penetrating Trauma	32	65	12
Surgical	28 (88%)	59 (90%)	10 (83%)
Nephrectomy	14 (43%)	25 (39%)	4 (33%)
Repair	14	33	6

Table 2. Penetrating Renal Trauma Due to Gunshot or Knife in Groups II (1973–1984) and III (1985–1988).

	Group III		Group III	
	Gunshot	Knife	Gunshot	Knife
Total Number	58	7	10	2
Surgical	55	4	8	2
Nephrectomy	25	0	4	0

Table 3. Associated Injuries in 92 Patients (Group III) 1985–1988.

Blunt Trauma	80	Penetrating Trauma	12
Head	25	Colon	6
Chest	17	Spleen	5
Pelvis	13	Stomach	3
Long Bone Fracture	13	Pancreas	3
Spleen	12	Liver	2
Liver	10	Small Bowel	2
Femur	5		
Rib Fracture	4		

Table 4. Classifications of Injuries in Groups II (1973–1984) and III (1985–1988).

	Group II	Group III
Class I		
Penetrating Trauma	4	5
Blunt Trauma	153	69
Class II		
Penetrating	33	3
Blunt	23	6
Class III		
Penetrating	28	4
Blunt	7	5

Discussion

In comparing our experience with renal trauma

between the three groups, we see that the incidence of renal trauma per year is not significantly different. Philosophy regarding the management has changed by adding newer imaging techniques not available in the 1960s. Now that there is better delineation of the injuries, a more informed decision can be made regarding the nonoperative approach to certain injuries without an increase in delayed morbidity or serious complications. Renal injuries were divided into two groups, penetrating or blunt. Penetrating injuries represent 20–30% of all renal injuries usually resulting from gunshot or stab wounds and associated with other organ injuries in about 80% of cases.[5] Blunt injuries, on the other hand, account for approximately 70–80% of all renal injuries and usually result from motor vehicle accidents, falls, assaults, or participation in sports.[5]

The assessment of renal injury should be done in a systematic fashion. It should be based on suspicion or likelihood of injury and should include a history, physical examination, and the presence and extent of hematuria. Classically, renal evaluation has been performed by intravenous pyelography with nephrotomography. Useful information obtained with intravenous pyelography includes establishing the presence or absence of a kidney, defining the renal outline and parenchymal borders, and outlining the collecting system and ureters. With tomography, there may be better delineation of parenchymal lacerations, intrarenal hematomas, and evidence of poor parenchymal perfusion.[6] The more severely injured the kidney is, the less accurate is an IVP for staging. In addition, patients with multiple injuries are often poorly prepared for pyelography and may be hemodynamically unstable. If an intravenous urogram is inconclusive, additional studies should be obtained. Since most trauma centers have CT imaging techniques available on an immediate 24-hour basis, this modality has replaced retrograde pyelography and arteriography as a first-line test for renal trauma. Figure 1 shows the algorithm used at our institution for the initial management of patients with a suspected renal injury. The advantage of the CT scan is that it gives three-dimensional views, it is not invasive, provides definition of parenchymal lacerations more clearly, demonstrates extravasation, outlines nonviable tissue, defines the extent and size of the surrounding hematoma, and detects associated injuries.[6] Although an arteriogram has been recommended for the delineation of damage, it is unusual that more information is needed than is obtained by CT examination. The one exception is nonenhancement of the kidney parenchyma on CT scan, where it may be helpful to distinguish arterial thrombosis, avulsion of the pedicle, or vascular spasm.

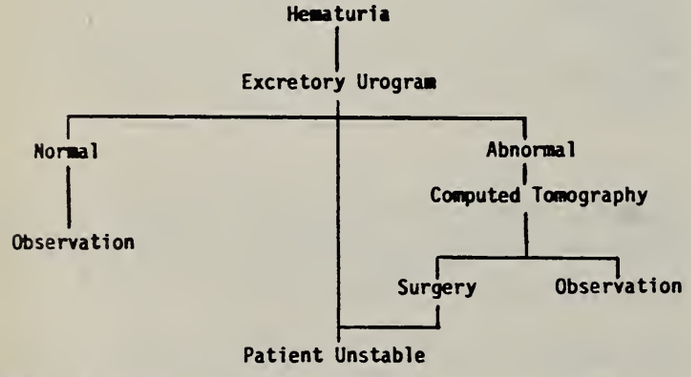

Fig. 1. Radiographic Imaging for Suspected Renal Injury.

Management of renal trauma has become nonoperative for selected patients suffering from blunt trauma and in some cases of penetrating injury. Although there are proponents of both early surgery and delayed surgery, specific indications for exploration have been well publicized by McAninch.[6] There are 1) expanding or uncontained hematoma, 2) pulsatile hematoma, 3) urinary extravasation, 4) nonviable renal parenchyma and 5) vascular injury. Our experience parallels that of McAninch.

When exploration is required, the principle of early pedicle control before any attempt is made to open Gerota's fascia is important. If bleeding does occur, the renal vessels can be occluded while renal repair is undertaken. If the patient is unstable and is brought directly to the operating room, associated injuries may require attention before treatment of the renal injury. In this situation, a high-dose IVP may be obtained on the operating table, looking for the presence of functioning kidneys. If this study is normal, exploration can be avoided, whereas if abnormal, exploration using the surgical techniques above can be undertaken.

Following these guidelines, we have shown at our institution a steady decrease in the number of patients with blunt trauma requiring exploration and the number of nephrectomies required.

Of concern to us is the persistence of a high percentage of patients requiring exploration and nephrectomy following penetrating wounds, especially from gunshot. We have the clinical impression that part of this results from the change in the type of weapon used on the streets in our city. In Group I, it was our impression that a number of these wounds were due to weapons of 22, 25, 32, and 38 caliber. These weapons have a relatively low muzzle velocity compared to the 9-mm weapons that are so common on the streets of our city. It has been reported that Richmond, Virginia, is awash in guns. Ten percent of Richmonders habitually go armed. It has been published recently[7] that one can purchase a 22 pistol for under $75. A 44 magnum can be purchased for $310 and a Uzi semiautomatic machine gun can be purchased for $450.

In the Spring of 1988, a Richmond woman bought thirty-seven M16 rifles over a three-day period from the same store.

Summary

In summary, with the ready availability of newer, more sensitive imaging modality such as CT scan on a

24-hour emergency basis, more accurate staging of renal trauma is possible and selection of cases for operative or non-operative management has become easier. This has meant that all but severe blunt renal trauma can be handled conservatively. Penetrating injuries from firearms have not shown any reduction in the loss of renal tissue. We would suggest that modern technologies have not helped the situation and only a change in public policy as it relates to gun control will prove to be effective.

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Endoscopic Injection Therapy for Acute Upper GI Bleeding

Gregg A. Valenzuela, MD, David McGroarty, MD, Eddy Pizzani, MD, and Thomas Davis, Jr., MD, *Richmond*

THERAPEUTIC endoscopy for acute non-variceal upper gastrointestinal (UGI) bleeding may be problematic because established therapies such as laser, bicap electrocoagulation, and heater probe cautery may be difficult to apply or ineffective. Injection therapy is a simple, inexpensive, experimental method in which an agent is injected into or around a bleeding lesion to affect hemostasis. Prospective randomized controlled trials are now being conducted to evaluate its place in the therapy of acute UGI bleeding. We present two of several recent cases illustrating how we have found this method to be useful in difficult patient management situations and also review the current literature.

Case Reports

Case 1. A 69-year-old female with undifferentiated small cell carcinoma had been hospitalized with leukopenia secondary to chemotherapy and sepsis. She had been improving but then developed hematemesis, found at emergent endoscopy to be due to a large duodenal ulcer. Attempted coagulation with heater probe was not entirely successful due to the location of the bleeding vessel in the immediate postpyloric area of the duodenal bulb. Bleeding continued and at repeat endoscopy 8 ml of 1:10,000 solution of epinephrine and saline was injected. The patient did well for about six days and was started on a soft diet and again developed hematemesis. She was again endoscoped and bleeding at the same site was found. It was injected with another 3 ml of 1:10,000 epinephrine with cessation of bleeding. Two days later, she underwent another endoscopy to assess the ulcer. This revealed a large duodenal ulcer which encompassed 75% of the bulb. There was active oozing, and it was injected simply with 3 ml of normal saline solution. The patient had no further evidence of bleeding and repeat endoscopy one month later revealed a persistent benign ulcer.

Case 2. A 75-year-old female with a history of chronic obstructive lung disease, hypertension, and

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peripheral vascular disease presented to the emergency room with hematemesis. She had had vascular surgery two months prior and had been taking aspirin 325 mg twice daily as well as iron supplements, which had turned her stools dark. Physical examination revealed a blood pressure of 80/40 and a soft abdomen with hyperactive bowel sounds. There was melenic stool in the rectal vault and the nasogastric aspirate was bloody. She was given 2 units of packed red blood cells and underwent emergent upper endoscopy. A 4-cm lesser curve gastric ulcer was identified with an actively bleeding visible vessel. Because of the angle of approach, coaptive coagulation could not be readily accomplished with the heater probe. Injection with 2 ml of 1:10,000 solution of epinephrine, however, was effective in completely stopping the bleeding. This allowed for better visualization and localization of the pathology. The vessel was then coagulated with the heater probe. There was no subsequent bleeding and followup endoscopy one month later revealed nearly complete reepithelization of the ulcer.

Discussion

These cases illustrate our current use of injection therapy for active upper gastrointestinal bleeding in treating patients impossible to treat with coagulation therapy. This method requires little equipment and is technically easy. A standard 23-gauge sclerotherapy needle is passed through the therapeutic channel of the upper endoscope. Injections of 0.5-1.0 ml of a 1:10,000 epinephrine solution are made submucosally around the bleeding lesion and repeated as necessary. A further injection of the bleeding vessel itself may be made if desired and a total of 5-10 mls may be used. This method has facilitated the use of the heater probe for coaptive coagulation and in several instances has allowed us to forego high-risk surgery.

There is a growing literature concerning this technique. Unfortunately, most studies have been uncontrolled, non-randomized and/or retrospective. Hirao et al reported in 1985 on the use of hypertonic saline and epinephrine in the treatment of active bleeding lesions.[1] They accomplished immediate hemostasis in 98% and permanent hemostasis in 94% of patients. They reendoscoped patients at 24-48 hours and reinjected those with visible vessels. Compared to historical controls, the emergency surgery rate fell from 21.7 to 13.3%. Prophylactic treatment of non-bleeding visible vessels resulted in a rebleeding rate of only 0.8%. In 1987 Leung et al reported on the use of epinephrine injection in the treatment of actively bleeding patients with ulcers.[2] There was an initial success of 100%, with 87% long-term hemostasis and an 8.1% surgery rate. They note advantages of this form of therapy as 1) the ability to treat a bleeding source even through overlying clot; 2) initial injection may decrease bleeding enough to allow other therapy to be applied; and 3) it may be applied in areas technically difficult to reach with other methods. Soehendra et al in 1985 reported similar results using epinephrine followed by the sclerosant polidocanol.[3] Permanent hemostasis was achieved in 98% of active bleeders. Asaki et al reviewed their large experience with injection of absolute alcohol and found it to very efficacious in the initial treatment of massive bleeding with shock.[4] It allowed only a 4.4% surgery rate and a 2.2% mortality rate. Sugawa et al had less success treating active GI bleeding with alcohol.[5] They reported an initial hemostasis in 92% and only an 8% rebleeding rate but had a 29% rate of emergent surgery. Chen et al compared alcohol and epinephrine with hypertonic saline in a prospective randomized trial in patients with stigmata of recent bleeding (black spots were accepted as stigmata) within 48 hours of acute bleeding.[6] Low rates of rebleeding were noted, 91 and 88% respectively. Di Felice treated 19 actively bleeding patients with epinephrine and polidocanol and found a 100% rate of permanent hemostasis.[7] In the only prospective randomized controlled trial comparing injection with a known effective treatment, Laine found that alcohol was equally as effective as bicap in limiting transfusions, emergency surgery, hospital days, costs, and mortality.[8]

In addition to those noted above, a variety of sclerosing solutions have been used for injection therapy of gastrointestinal bleeding, including polidocanol and thrombin.[9–12] This may be due to the fact than any material that is injected adjacent to a bleeding vessel may decrease bleeding because of compression of the vessel. Subsequent vasoconstriction, vessel thrombosis, sclerosis, and/or edema induced by an active agent may help prevent recurrent bleeding. Followup treatment with thermal coagulation after initial hemostasis achieved by injection has been recommended as a way to prevent rebleeding.[9] Concerns about perforation with sclerosing agents and absolute alcohol have not been substantiated, but a larger experience will be needed before their safety is established.

Summary

In summary, we have found this technique to be useful in patients in whom coagulation therapy is not possible or effective. It must still be considered a technique which is undergoing evaluation. Prospective randomized trials comparing this therapy with other currently available therapies such a electrocoagulation, laser and conservative management must be completed to firmly define its place in treatment strategy for acute upper GI bleeding.

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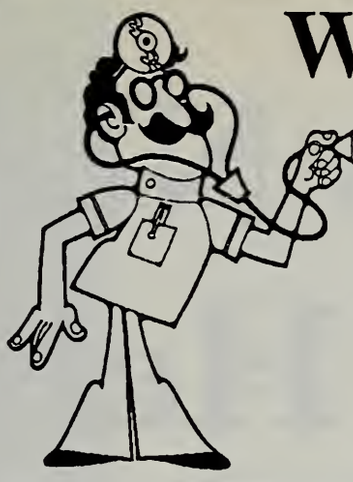

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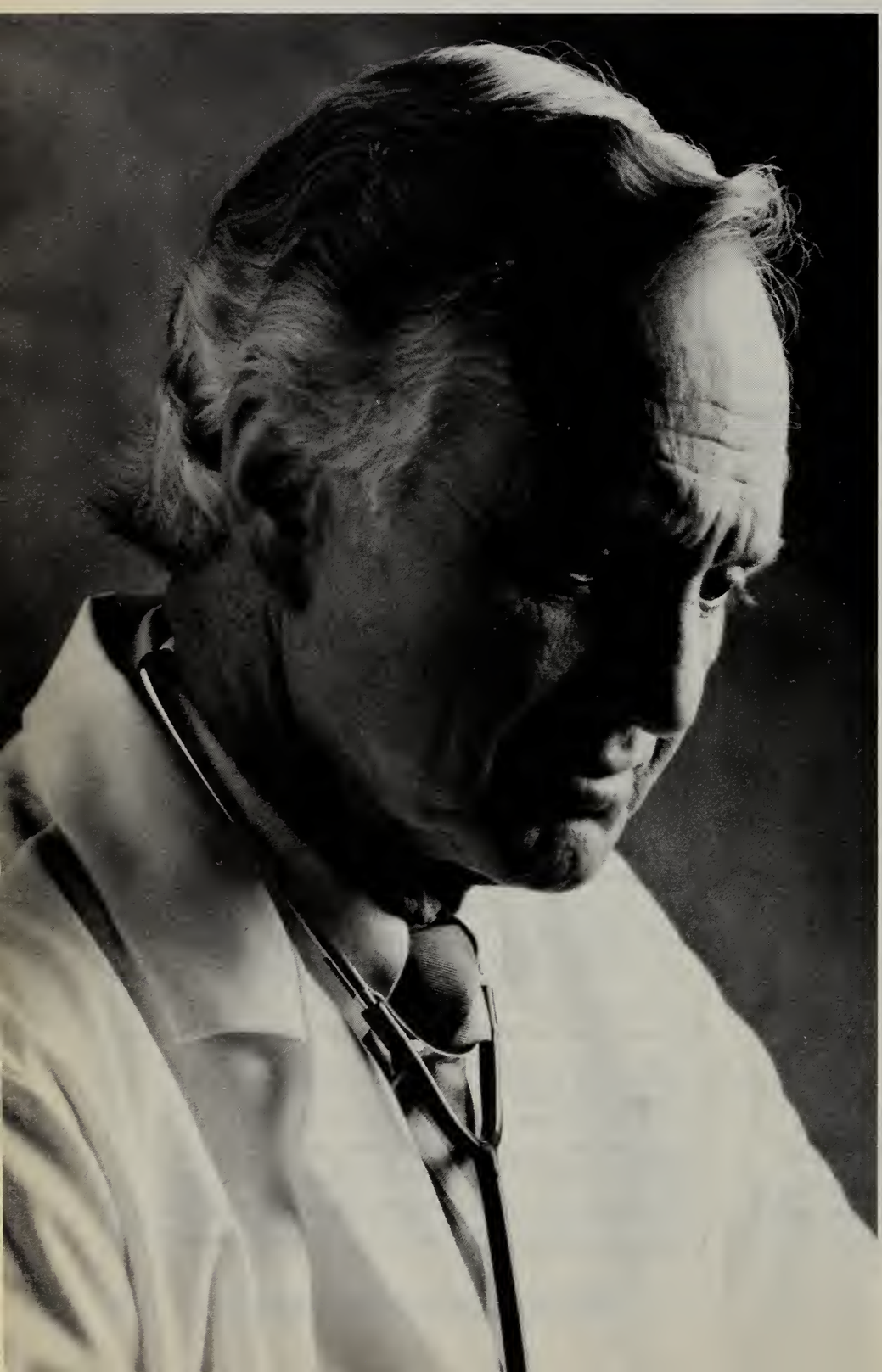

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ABSTRACTS

These are abstracts of some of the papers presented at the Conference on Gastroduodenal Disease and Campylobacter pylori *at the University of Virginia on May 10–12, 1989, in Charlottesville. The conference was arranged by B. J. Marshall, MD, R. L. Guerrant, MD, and R. W. McCallum, MD, Charlottesville, and W. L. Peterson, MD, Dallas. It was sponsored by the National Institutes of Health and Procter & Gamble.*

A Pig Model for *Campylobacter pylori* Gastritis: Systemic Antibody Response. Lars Engstrand, Anne Jorgensen, Anne Schwan and Sven Gustavsson, University Hospital and National Veterans Institute, Uppsala, Sweden.

The aims of these experiments were to establish growth of *Campylobacter pylori* (CP) in the gastric mucosa of barrier-born pigs and to study local inflammatory and systemic immune responses.

Nine barrier-born pigs (specific pathogen free, SPF) of Swedish land-race were pretreated with omeprazole and inoculated with CP, 10^7–10^9 bacteria, at gastroscopy. In 4 pigs the inoculation was repeated twice with increasing number of bacteria during two weeks. Two pigs served as controls. The pigs were observed for 12 weeks. Endoscopy with biopsy was repeated weekly for four weeks and then every other week. CP was detected by routine culture technique and by immunoper-oxidase staining using a CP-specific monoclonal antibody. The systemic antibody response was determined by ELISA using whole bacteria from the inoculate as antigen.

From two control pigs CP was never cultured and so serum antibody specific for CP was detected. In 5 to 7 inoculated pigs CP grew throughout the 12-week observation period. In all colonized pigs the antibody titers increased 3–4 weeks after inoculation and remained at high levels during the remaining observation period. We have observed development of focal, superficial gastritis with predominantly mononuclear cell infiltrates.

We conclude that it is possible to establish growth of CP in the stomach of barrier-born pigs. The development of gastritis and systemic antibody response support the usefulness of this model for CP-related human diseases.

Comparisons of Two Antigens for the Evaluation of Antibody Response in *C pylori* Infection. E. Mathai, A. Tobin, S. Beattie, M. Cafferkey, C. T. Keane and C. O'Morain, Adelaide/Meath Hospitals, Trinity College, Dublin, Ireland.

Recent studies using acid glycine extract (AG) from *C Pylori* as antigen have shown specific antibody response in patients infected with *C pylori*. However this antigen is difficult to prepare. We compared the antibody response as detected by AG in indirect enzyme linked immunosorbent assay with a new antigen preparation—supernatent from the sonicate (SS) of *C pylori* in patients with *C pylori* infection. The proteins in both antigenic preparations were evaluated by SDS-PAGE. Sera from microbiologically proven negative cases were used to determine a cut off value for a significant ELISA test. One hundred and eighteen *C pylori* positive and 40 negative patients were included in the study. In the *C pylori* positive group 109 had elevated levels of antibodies using SS antigen as against 103 by AG. None of the 40 *C pylori* negative patients were ELISA positive using SS antigen, while 1 showed elevated levels by AG. Hence the sensitivity, specificity, positive and negative predictive values for ELISA test using SS antigen were calculated to be 92.4%, 100%, 100% and 81.6% and that of ELISA using AG were 87.3%, 97.5%, 99% and 72.2% respectively. SDS-PAGE on the 2 antigen preparations showed similar major bands, however SS had more minor bands than AG. Electrophoresis also showed that none of these had extracted the flagellar antigens, the major cross reacting antigen to any great degree. SS, an antigen much easier to prepare than the AG gives better predictive values in detecting *C pylori* associated infections and is therefore a better candidate for use in routine screening tests.

Rapid Identification of *Campylobacter pylori* Using Monoclonal Antibodies Directed Against Outer Membrane Proteins. R. D. Shadowen and C. V. Sciortino, Medical University of South Carolina and Veterans Administration Medical Center at Charleston.

C pylori has been implicated as an etiological agent in gastritis and peptic ulcer disease. However, due to the lack of a sensitive and specific test for the organism, its role in the pathogenesis of this disease has not been well defined. We used outer membrane preparations of *C pylori* to immunize mice and prepare a hybridoma library of 29 distinct monoclonal antibodies (MABS). Two of these MABS were selected for their generalized reactions with several *C pylori* strains. A fluorescent antibody stain and staphylococcal coagglutination assay were then developed. Specificity for each test approaches 100% revealing no cross reactions with other oxidase-positive or common gram-negative enteric pathogens. The fluorescent antibody stain demonstrates 99% sensitivity for *C pylori* and the coagglutination assay can detect as few as 100 bacteria from culture. We anticipate that the use of these tests will enhance our ability to identify and investigate the role of *C pylori* in disease.

***Campylobacter pylori* Prevalence in Patients Undergoing Upper Endoscopy.** T. T. Schubert and G. A. Schnell, University of Missouri School of Medicine, Kansas City, Missouri, and Henry Ford Hospital, Detroit, Michigan.

From August 1987 through July 1988 we evaluated antral biopsy specimens for *Campylobacter pylori* (CP) in 212 patients undergoing upper endoscopy. In those patients who had multiple endoscopies, the *Campylobacter* status was determined using the first endoscopy in which a urease test, histology and culture were done. A patient was regarded as *Campylobacter* positive if the culture was positive or if both a urease test and the histology were positive.

Blacks had an increased CP positivity (61.2%) compared to whites (31.5%). Among non-ulcer patients CP positivity was 52% in black patients and 18% in white patients. Age and gender were unrelated to CP positivity among controls and those without ulcers. There was an increased *Campylobacter* positivity in patients with duodenal ulcers (85%) compared to those without ulcers (37%) and a trend towards increased positivity in those with gastric ulcer (53%) and duodenitis (50%). There was no increased *Campylobacter* positivity in patients with gastroesophageal reflux disease (28%), gastritis (29%), non-ulcer dyspepsia (43%) or the control patients with no gastroduodenal mucosal abnormalities (40%). DU patients CP negative were older (average 71 yrs) than CP positive DU patients (43 yrs) and female DU patients had a lower CP positivity (71%) compared to males (94%).

Adjuvant Antibiotic Treatment Improves Eradication of *Campylobacter pylori* in Duodenal Ulcer. T. O'Riordan, A. Tobin, S. Beattie, C. O'Morain, E. Sweeney and C. Keane, Meath/Adelaide Hospitals, Dublin, Ireland.

Persistence of *Campylobacter pylori* (CP) after duodenal ulcer (DU) healing is associated with high rates of ulcer relapse. We compare a number of adjuvant antibiotic regimens designed to achieve optimal CP clearance in patients with DU and an associated CP positive antral gastritis. All patients had 2 antral biopsies performed before treatment which were assessed for histological evidence of gastritis and independently for CP studies using microscopy, gram stain, culture and Warthin-Starry stain. The patients were allocated to 5 treatment groups. All patients received colloidal bismuth subcitrate 120 mg qid for 4 weeks. Endoscopy and antral biopsies were repeated 4 weeks after completion of treatment. The groups were 1) no adjuvant antibiotics (n = 23); 2) amoxycillin 500 mg tid for 7 days (n = 18); 3) metronidazole 200 mg tid for 7 days (n = 23); 4) metronidazole 400 mg tid for 7 days (n = 20); and 5) metronidazole 400 mg tid and amoxycillin 500 mg tid for 7 days (n = 20). CP eradication rates in groups 4 and 5 were significantly higher at 85% than groups 1, 2, and 3 (43%, 50% and 57% respectively) $P < 0.05$). The results achieved using metronidazole at a dose of 400 mg tid were not improved by the addition of amoxycillin. No significant antibiotic toxicity was encountered during the study. We conclude that metronidazole 400 mg tid for 7 days should be used as adjuvant treatment in patients with DU and an associated CP positive gastritis.

Ammonia Produced by the Hydrolysis of Urea Is Cytotoxic to Gastric Epithelium In Vitro. D. T. Smoot, J. F. Lewison and J. H. Resau, University of Maryland School of Medicine at Baltimore.

Campylobacter pylori (CP) has been found in greater than 80% of adult patients with histological evidence of antral gastritis. The mechanism by which this organism causes gastritis is unknown. Earlier work by this laboratory has shown that inhibition of CP urease activity prevents gastric epithelial cell injury in vitro. These data imply that ammonia liberated by hydrolysis of urea is cytotoxic. To test this hypothesis, a human gastric adenocarcinoma cell line (CRL 1739) was exposed to urease purified from Jack Beans. The cells cultured in Ham's F12 media supplemented with 10% fetal bovine serum and varying concentrations of urea (1-25 mM) were grown in 24 well tissue culture dishes for 24 hours and then exposed to urease at a concentration of 0.1 mg/ml (50 μMol units/mg). Cells cultured in media without urea were used as controls. After 24 hours of exposure to urease, cell viability was assessed by incorporation of neutral red dye (NRI) and cellular morphology.

	Media Urea Concentration					
N = 4	1mM	5mM	10mM	15mM	20mM	25mM
Viability (NRI)*	96	83	80	64	50	36
Ammonia (mM/L)**	4	15	21	33	40	54

Urease exposure induced cell injury as evidenced by a decrease in the incorporation of neutral red which was directly proportional to the ammonia concentration of the media. Morphologically cells exposed to high concentrations of ammonia rounded up and developed granular cytoplasm; the percentage of cells showing these mophological changes correlated inversely with NRI. Ammonia can produce functional and morphological alterations in gastric epithelium in vitro. Urease activity of CP is (1) likely important in its pathogenicity and (2) inhibition of this urease activity may be clinically useful.

Simplifying the Urea Breath Test for *C pylori*. B. J. Marshall, M. W. Plankey, S. Hoffman and R. W. McCallum, University of Virginia at Charlottesville.

C pylori may be diagnosed non-invasively with the urea breath test which in most reports has involved prolonged breath collection and ingestion of the isotope within a liquid meal. The aim of our study was 1) to see if a single breath sample could diagnose *C pylori* and 2) to find the ideal time to take the sample.

Patients who had undergone previous gastric resec-

tion were excluded from the study. Fasting patients cleaned their teeth then swallowed 5 uCi of ^{14}C urea in 15 ml of water. Breath was collected into glass bottles containing 1 mmol of hyamine in 2 ml of methanol. Samples were taken at 2 minutes (to assess mouth flora) and at 15, 20, 25 and 30 minutes after ingestion of the isotope. They were counted in a beta counter and results were expressed as counts per minute (CPM), a value corrected for body weight (VALUE), and as an area under the excretion curve between 15 and 30 min (AREA). CP status was determined by histology and culture of multiple gastric biopsies taken at endoscopy. The normal range of ^{14}C excretion was defined as the mean + 3SD of that seen in the CP− patients. Results: 49 CP + patients and 55 CP− patients had their initial breath test during the study. In the table the upper limit of normal (M + 3SD) is in parentheses.

		15 min	20 min	25 min	30 min
CPM	sens. %	91 (1237)	95 (883)	94 (724)	94 (558)
	spec. %	98	96	98	98
VALUE	sens. %	91 (0.83)	93 (0.6)	94 (0.5)	93 (0.38)
	spec. %	98	96	98	98
AREA	sens. %	94 (1.67)	spec. %	98	

CPM on a single breath sample taken at 20 min gave a sensitivity and specificity of 95%.

We conclude that 1) a single collection at 20 min is sufficiently accurate for routine use; 2) correction of CPM for body weight does not improve the accuracy of the test. We recommend that in addition to the 20 min sample, collections at baseline and 2 minutes be considered as helpful in training the patient as well as alerting the investigator to possible methodological errors.

Naturally Occurring *Campylobacter pylori* (CP) Infection in the Cynomolgus (*Macaca fascicularis*) and Rhesus (*Macaca mulatta*) Monkey. A. R. Euler, G. E. Zurenko, J. B. Moe, R. G. Ulrich and R. D. Schaadt, the Upjohn Company, Kalamazoo, Michigan.

Campylobacter pylori (CP) is a gram-negative, microaerophilic, spiral-shaped bacterium implicated as a cause of human peptic ulcer disease. Primate animal model development would facilitate research into the etiology and therapy of this disease. Therefore, we undertook an endoscopic, histologic, and microbiologic evaluation of the cynomologous (CNM) and rhesus (RHM) monkey for the presence of naturally-occurring CP infection. Endoscopic antral and fundic biopsies were obtained from 12 CNM, and antral biopsies only from 34 RHM. Biopsies were examined histologically (Warthin-Starry, Giemsa, and H&E stains), and microbiologically (rapid urease test, culture on selective and non-selective media). No endoscopic or histopathologic abnormalities were observed in any CNM. CP was never isolated. However, a large tightly-spiraled organism (TSO) was found in abundance in parietal cell glands. There was no evidence of gastric inflammatory response. Electron microscopic examination of the TSO revealed a "spirochete-like" morphology: length = 4–7 μm, diameter = 0.6-0.8 μm, intercoil distance = 0.3-0.6μm, cell wall thickness = 20 nm bounded by inner and outer membranes, biopolar tufts of appendages. Attempted culture of the TSO was unsuccessful. Endoscopic findings for the RHM were as follows: antral erythema (8), "halo" lesions (4), gastritis (2), and normal (19). Histopathology included gastric lymphoid inflammation in 14 RHM, and gastric epithelial changes (mucinous hyperplasia, superficial metaplasia, or dilated glands) in 10 RHM. C pylori-like organisms (based on biochemical characterization) were isolated from 12 of 34 RHM. A general correlation existed between the positive was also observed in 29 of 34 RHM. Naturally-occurring CP infection was present in 0% and 35% of CNM and RHM, respectively. The RHM may be inherently more susceptible to CP than CNM, and represents an opportunity for primate model development.

***Campylobacter pylori* Infection in Patients at the University of Alabama.** C. H. Barrier, C. B. Alexander, D. C. Pellegrin, G. R. Cutter, B. I. Hirschowitz and M. F. Go, University of Alabama at Birmingham.

Campylobacter pylori (CP) is a gram-negative spiral microorganism commonly found in the gastrointestinal tract. Over a 20-month period from January, 1987 to August, 1988 a total of 178 consecutive patients referred for upper endoscopy were evaluated for the presence of CP by histological and culture techniques. Culture and histological results were obtained independent of each other. The patients were separated into different diagnostic groups after completion of culture and histology of antral biopsies taken during the endoscopic procedure.

Diagnosis	No. patients (%)	No. CP+ (%)
Gastritis	48 (26.9%)	19 (39.6%)
Duodenal ulcer	42 (23.6%)	33 (78.6%)
Gastric ulcer	15 (8.5%)	9 (66.7%)
Esophagitis	18 (10.1%)	7 (38.9%)
Normal	36 (20.2%)	13 (36.1%)
Other	19 (10.7%)	9 (47.4%)
Total	178 (100%)	90 (50.6%)

The data was further analyzed for bias in variables including age, sex and race.

We conclude that 1) the prevalence of CP in our population was lower than expected and 2) this was expecially evident in the gastritis diagnosis group.

***Campylobacter pylori* Infection: Evidence for a Worldwide Distribution and a High Prevalence in Developing Countries.** F. Megraud, M. P. Brassens-Rabbe, F. Denis, M. Touhami and D. Q. Hoa, Hospital des Enfants, Bordeaux, France; Centre Hospitalier Dupuytren, Limoges, France; Clinique Amilcar Cabral, Oran, Algeria; and Centre de Pediatrie, Ho Chi Minh City, Vietnam.

Campylobacter pylori infection is now recognized as a major factor in gastroduodenal pathology. Studies in developed countries have shown that asymptomatic *C pylori* infection is frequent and that the prevalence increases with age. Few data are presently available in developing countries. The aim of the study was to determine the prevalence of the infection in 3 countries on 2 continents by a population-based study using serology. One thousand sera were collected. In Vietman and Algeria, adult sera were collected in blood banks; sera from children were collected at outpatient clinics. In the Ivory Coast, sera from adults and children were collected by cluster sampling. Sera from a French health center were also included as a control.

An ELISA with a sonicata as antigen was used. It was standardized with sera from patients known to be *C pylori* positive or negative resulting in a specificity of 96% and a sensitivity of 84%.

In all 3 developing countries, an increased prevalence with age was noted. The major difference with data from developed countries was the very high prevalence of the infection; 75% or higher from the third decade on. Children were contaminated early in life (= 50% by age 10) except in Vietnam, in contrast to that seen in developed countries. No difference was noted between men and women in any country. The place of residence (urban or rural) studied in Vietnam was not associated with *C pylori* infection.

We conclude that, with the given prevalence, *C pylori* is probably a mild pathogen. However, it could very well contribute to gastric atrophy already observed in a large proportion of the population by age 30 and to gastric discomfort which is common in these countries.

***Campylobacter pylori* in Chronic Duodenal Ulcer and the Zollinger-Ellison Syndrome.** A. Fich, N. J. Talley, R. G. Shorter and S. F. Phillips, Mayo Clinic, Rochester, Minnesota.

Since *Campylobacter pylori* is present in nearly all patients with chronic duodenal ulcer (CDU), it has been hypothesized that *C pylori* plays a pathogenetic role. We postulated that, if *C pylori* is pathogenic in the usual form of CDU, it would be infrequent in patients with duodenal ulcer of specific etiology, such as the Zollinger-Ellison syndrome (ZES).

Gastric tissue was available from 12 patients with ZES and 18 patients with CDU, all of whom had undergone elective gastric resections. Antral tissues were cut (5 μm thickness) and stained by hematoxylin-eosin and Giemsa. All slides were reviewed by an independent experienced pathologist who was unaware of the diagnosis. Chronic and active chronic gastritis was graded from 0 (no inflammatory cells) to 4 (very dense cellular infiltrate). *C pylori* were recognized morphologically by the presence of typically curved, rod-shaped organisms.

The prevalence of antral *C pylori* in patients with ZES was significantly lower than that in patients with CDU ($p < 0.05$). Moreover, chronic antral gastritis scores were significantly higher in patients with CDU compared to ZES patients ($p < 0.05$).

	Z-E Syndrome n = 12	Chronic Duodenal Ulcer n = 18
Age (mean + SEM)	43.8 ± 3.4	48.6 ± 3.4
Sex M/F	6/6	9/9
Prevalence of *C. pylori*	4/12	16/18
Gastric score	1.5 ± 0.2	2.4 ± 0.2

We confirm that CDU is strongly associated with the presence of *C pylori* in antral mucosa. In contrast, the prevalence of *C pylori* in duodenal ulcer secondary to Zollinger-Ellison syndrome was markedly less and was, in fact, similar to the prevalence reported in healthy volunteers. These data support the hypothesis of a role for *C pylori* in the induction of CDU.

Can *C pylori* Be Eradicated? Long-Term Followup on 28 Successfully Treated Patients. B. J. Marshall, S. H. Caldwell, S. R. Hoffman, H. F. Frierson, R. L. Guerrant and R. W. McCallum, University of Virginia at Charlottesville.

C pylori does not usually respond to single agent antibiotic therapy and many investigators have reported recurrence after apparent clearance of the bacterium. The purpose of this study was to identify criteria which could be used to define bacteriologic cure.

114 patients with biopsy proven *C pylori* were treated with at least 14 days of bismuth subsalicylate concurrently with an antibiotic, either metronidazole 1-1.5 g/day, amoxicillin 2 g/day or erythromycin 2 g/day. Endoscopy with multiple gastric biopsies for histology, culture and CLO test and/or 14C urea breath test were performed 28 days after therapy. All patients were then asked to return for repeat evaluations at 3, 6, and 9 months after initial clearance.

At assessment 28 days after therapy there were 58 patients cleared of *C pylori*. In 28 patients, at least one subsequent study has been performed at times ranging from 1 to 10 months after initial clearance. Specifically, 22 patients have been evaluated for at least 3 months, 9 for 6 months, and 5 for 9 months, representing a total of 125 patient months of follow-up. No patient has been found to be reinfected.

We conclude: 1) Eradication of *C pylori* is achievable. 2) Endoscopic and/or breath test evidence of *C pylori* clearance four weeks after therapy is predictive of long-term cure. 3) Reinfection with *C. pylori* is apparently uncommon in the United States.

***Campylobacter pylori* Gastritis After Ulcer Surgery.** S. H. Caldwell, B. J. Marshall, M. W. Plankey, H. F. Frierson, S. R. Hoffman, R. W. McCallum, University of Virginia at Charlottesville.

Campylobacter pylori (CP) infection is present in over 90% of duodenal ulcer (DU) patients (pts) and

over 70% of gastric ulcer (GU) pts. It is suspected that infection plays a permissive role in peptic ulceration. Acid-reducing surgery is effective therapy for peptic ulcer and post-operative relapse rates of 0.8–20%. Little is known about the course and significance of the infection after surgery. Our goal was to study this process in pts who have had acid-reducing surgery at UVa for peptic ulcer since 1980.

21 pts out of 209 identified through chart review met criteria and agreed to participate in the study. Of the original 209, 70 were excluded due to age over 75 yr, 52 due to death, Zollinger-Ellison syndrome or medical problems, 29 could not be reached, 37 were uninterested. Of the 21, 11 had parietal cell vagotomy (PCV), 8 had vagotomy and antrectomy (VA) and 2 had vagotomy and pyloroplasty (VP). All pts underwent C14 urea breath test and serologic testing and 12 (7 PCV, 4 VA, 1 VP) underwent endoscopy and biopsy. 3 pts who were CP+ have been treated and had repeat biopsy. All pts completed symptom and history questionnaires.

13 pts were CP+ (62%). 8 of 13 with antrums in situ were CP + and 4 of 8 with antrectomy were CP +. By original diagnosis, 10 of 13 DU pts were CP+ after surgery, 3 of 6 GU were CP+ after surgery and 1 of 2 with either channel ulcer or DU and GU were CP+. The mean time since surgery for CP+ was 44 mo. and for CP− it was 42 mo. Among CP+ pts, 9 of 13 underwent endoscopic biopsy and all had histologic gastritis. 3 of 8 CP− pts had biopsy and all had normal gastric histology or had evidence of bile effect (foveolar hyperplasia) without inflammation. Repeat biopsy in the 3 CP+ pts treated with antibiotics showed marked histologic improvement. Symptom scores were similar in CP+ and CP− but more CP+ were regularly using medications (61 vs 38%). 4 pts (19%), all PCV, had suspected or proven ulcer relapse and all were CP+.

We conclude: 1) CP is common after ulcer surgery regardless of type of surgery or time since surgery. 2) In this setting, CP is associated with histologic gastritis and eradication of the organism heals the gastritis. 3) Though this is a small study, it suggests that the success of surgery for peptic ulcer may relate not only to the traditionally accepted acid reduction but also to the presence or absence of CP.

***Campylobacter pylori* in Dyspeptic Elderly Patients.** T. O'Riordan, A. Tobin and C. O'Morain, Meath/Adelaide Hospitals, Dublin, Ireland.

The association between *Campylobacter pylori* (CP) and gastritis is well established. As there is evidence that CP infection increases with age we reviewed the clinicopathological records of 119 consecutive patients aged 65 to 85 years (mean 71.1 years) on whom gastroscopy had been performed for dyspeptic symptoms. The male/female ratio was 7:6 and the ratio if inpatient to day case patients was 1:3. All patients had 2 antral biopsies—1 was assessed for histological evidence of gastritis and the other was independently assessed for CP using microscopy gram stain culture and Warthin-Starry stain. 36 patients (30.2%) had duodenal ulceration, of whom 32 had an associated CP positive gastritis. 5 patients (4.2%) had a benign gastric ulcer and all had an associated CP positive gastritis. 49 patients (41.2%) had antral gastritis without ulceration, of whom 38 were CP positive and 11 were CP negative. 91% of CP negative gastritis patients had a history of recent ingestion of NSAIDs compared to 29% of CP positive gastritis patients. 3 patients with gastritis had a history of recent alcohol abuse (2 were CP positive). 10 patients (8.4%) had normal antral mucosa but had evidence of reflux oesophagitis (one of these patients was CP positive). 19 patients (15.9%) had normal antral mucosa and normal endoscopic findings and two of these were CP positive.

We conclude that CP infection is associated with the majority of cases of symptomatic gastritis in the elderly and that a CP positive gastritis is associated with the majority of duodenal ulcers in this age group. The most important cause of CP negative gastritis in this population appears to be NSAID ingestion.

***C pylori*-Related Non-Ulcer Dyspepsia Improves After *C pylori* Eradication.** L. George, R. Taylor, S. Noonan, P. Cole, L. Hyland, A. Morgan, J. Lenne, D. Moore-Jones, S. Brandl and T. Borody, Centre for Digestive Diseases, Sydney University, Sydney, Australia.

Controversy continues as to whether C pylori (CP) can contribute to the etiology of non-ulcer dyspepsia (NUD). Since blinded "triple therapy" results (Borody T et al, Gastroenterology 1988;94:A43) are not yet available, we reviewed symptoms retrospectively in NUD patients at least 6 mons after successful (−ve at 8 weeks rebiopsy) triple therapy. Records identified 62 NUD patients at least 6 months post-triple therapy for CP + ve gastritis. Only those with no endoscopic evidence of oesophageal inflammation or ulceration were included. Symptoms of abdominal pain (AP), nausea (N) and eructation (E) were scored on a linear analog scale.

Changes in symptom scores at 6 months or more post-therapy were seen in pain, nausea and eructation.

	Before Therapy	After Therapy	'p*'
AP −	6.2	2.5	<0.001
N −	2.0	0.8	<0.001
E −	3.4	2.0	0.01

Globally 60/62 patients stated that the positive symptom improvement warranted the 4 week therapy. These results need to be interpreted in light of retrospective methodology used.

We conclude that 1) treatment of CP-related NUD appears to relieve abdominal pain, nausea and eructation and 2) randomised trials are warranted in CP-related NUD.

Prevalence of *Campylobacter*-Like Organisms (CLO) in Antral Mucosa of Patients with Dyspepsia. Rafael A. Mosquera, Carmen González, Esther Torres, and Carlos Rubio, University of Puerto Rico at San Juan.

The purpose of this study was to determine the prevalence of CLO in antral mucosa of patients referred for elective upper endoscopy. 120 patients who did not have esophageal cancer, gastric cancer or gastric surgery from January to July 1988 were included. Endoscopic diagnosis were erosive gastritis, non-erosive gastritis, gastric ulcer, duodenitis, duodenal ulcer and normal. Antral biopsies classified as chronic non-active gastritis, active gastritis and no evidence of gastritis. Upon examination of the relationship between histologic diagnosis and prevalence of CLO it was found that 81% of patients with active gastritis had *Campylobacter*-like organisms when examined with acridine orange, as compared with 63% of chronic non-active gastritis, 57% of normal.

The association between active gastritis and *Campylobacter* was found to be statistically significant when compared with chronic non-active gastritis and normal.

***Campylobacter* and the Gastric Pre-Cancerous Process.** Pelayo Correa, Louisiana State University Medical Center at New Orleans.

Multidisciplinary research has led to the postulation of an etiologic model of gastric carcinogenesis (Ca Res 1988;48:3554–3560). The most common histologic type of gastric cancer is preceded by a prolonged process of progressive mucosal damage which includes the stages of superficial gastritis, gland loss (atrophy), intestinal metaplasia and dysplasia. The sequence of lesions is most commonly multifocal and involves the antrum and corpus. In populations at very high gastric cancer risk, multifocal atrophic gastritis (MAG) is very prevalent and heavily infected with *Campylobacter pylori* (CP). In populations at low risk of gastric cancer, the predominant type of gastritis is diffuse antral (DAG), an apparent forerunner of duodenal ulcer which does not involve gland loss (atrophy). CP may be the most important cause of DAG, probably not a cancer precursor. In the progression of MAG to dysplasia and cancer, 3 main etiologic factors have been postulated: a) initiating genotoxic agents which damage DNA, b) promoters which enhance cell replication and amplify the effects of the genotoxic abnormalities and c) inhibitors of either of the above mechanisms. There is no evidence that CP-induced DAG and duodenal ulcer increase cancer risk, which provides no grounds for a role of CP carcinogenesis under such circumstances. On the other hand, promotion of carcinogenesis within the MAG-metaplasia-dysplasia complex is well recognized and excessively salty food has been implicated. It appears, therefore, that CP does not induce cancer by itself (not a sufficient cause) but may act as a promoter when other causative (genotoxic) factors are present. It could be postulated that genotoxic factors are absent in DAG but present in MAG and therefore CP may be a cancer promoter in the latter but not the former type of chronic gastritis.

Relation of CP to GI Symptoms in Patients Undergoing Endoscopy. T. Schubert, A. Sangal, C. Ma and A. Schubert, Henry Ford Hospital, Detroit, Michigan.

Original reports by Marshall et al indicated CP infection commonly results in bloating, belching and halitosis. Others have failed to demonstrate significant correlation of CP with specific GI Symptoms. We sought to determine the association of CP with specific GI symptoms by interviewing consenting patients immediately prior to endoscopy and correlating these symptoms with the presence of CP (as determined by either urease test, Warthin-Starry stain or culture of antral biopsy specimens). The table shows our results.

	Patients with Ulcers		Patients without Ulcers	
	CP+	CP−	CP+	CP−
No. Patients	11	12	30	45
Mean Age/SD	53.6/10.8	56.7/17.3	51.6/13.4	48.3/18.2
Males:Females	2.6	0.71	1.31	1.50
Nausea	5	5	13	23
Upper Abd Pain	6	10	19	21
Bloating	5	1	11	16
Belching	5	1	15	10
Halitosis	2	2	5	10
Heartburn	3	3	11	11
Diarrhea	0	4	3	6
Constipation	4	0	4	14

Belching appeared to be more common in patients with CP. Bloating was more frequent in CP+ ulcer patients than in those that were CP− but bloating was equal in prevalence in CP+ and CP+ non-ulcer patients. Other symptoms did not differ significantly in frequency although the sample was too small to be conclusive.

William H. Barney, MD,
President, 1989-1990, The Medical Society of Virginia

VIRGINIA MEDICAL

EDITORIAL

President Barney

It is a distinct privilege to introduce to you the President of The Medical Society of Virginia for 1989-1990, Dr. William Harper Barney. Experience, knowledge, and involvement at all levels of organized medicine have prepared Dr. Barney to lead The Medical Society of Virginia into the new decade of the Nineties.

Dr. Barney is a Central Virginia man. He was raised in Altavista where his father Dr. Quintus Harper was a family physician. After receiving a BS Degree in 1943 from Randolph Macon College, Dr. Barney attended medical school at the Medical College of Virginia, graduating in March of 1946. Internal medicine training was interrupted by military service at Fitzsimmons Army Hospital in Denver where he had specialized training in cardiac and pulmonary diseases. After completing Internal Medicine training at the Medical College of Virginia, Dr. Barney returned to Central Virginia, establishing his practice of internal medicine in Lynchburg in 1951 and continuing to the present.

Dr. Barney's activity and work in the community has extended well beyond the practice of medicine. He has served on the Lynchburg School Board and the board of directors for the Greater Lynchburg Chamber of Commerce. In 1958 he was recognized as the outstanding young man of the year by the Lynchburg Junior Chamber of Commerce. For years, Dr. Barney has organized the medical support team for the prestigious Virginia Ten Miler race. He successfully campaigned, years ago, for a physician seat on the Lynchburg-Marshall Lodge Hospital board of directors and then became the first physician elected to that seat. He has also served the hospital as chief of staff.

Dr. Barney has been involved at every level of organized medicine. He has held multiple offices for the Lynchburg Academy of Medicine, including past chairman of the Public Relations Committee; current chairman of the Legislative Committee; and past president of the Lynchburg Academy of Medicine.

The experience and involvement of Dr. Barney in The Medical Society of Virginia manifest his energy and dedication to the physicians of Virginia. He began as a delegate to The Medical Society of Virginia from Lynchburg in 1957. He has been a member of the Public Relations Committee, the Commission on Medical Education, and Vanguard. In 1976, he was a citizen member of the Legislative Subcommittee of the Virginia State House of Delegates on malpractice. He traveled the state speaking and taking part in discussions regarding malpractice which benefited the entire physician population of Virginia. In 1980 Dr. Barney was assigned to a committee to study the needs of impaired physicians in the Commonwealth. In 1982 he became the first chairman of the Physicians' Health and Effectiveness Committee and remains on that committee as an advisor.

More recently Dr. Barney has served the Society as Vice Speaker and Speaker of the House of Delegates, President Elect, and a member of the Virginia delegation to the AMA.

Bill's boundless energy and dedication to The Medical Society of Virginia was interrupted briefly in January of 1988 when he suffered a myocardial infarction at a Medical Society of Virginia meeting in Richmond. Those of us who have had the privilege of knowing and practicing with Bill Barney in Lynchburg were not surprised that following cardiac catheterization and angioplasty, he would return quickly to practice and active service to The Medical Society of Virginia. Undaunted in his dedication to the Society and with a renewed interest in rehabilitation exercise, it is not unusual to arrive at the hospital at the time Bill

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is completing his cardiovascular workout.

Dr. Barney is married to the former Vivian Edmondson of Damascus, Virginia. They have three sons—Harper, David, and Richard. Each of the sons enjoyed active track careers at E. C. Glass High School. Perhaps that explains Bill's interest in the Virginia Ten Miler. After the temporary setback of January 1988, he is hale and hearty. Medical Society of Virginia members had better put on their running shoes because an active year of dynamic leadership by Dr. William Barney lies ahead.

JEFFREY W. WILSON, MD
5316 Hickory Hill Drive
Lynchburg VA 24503

Welcome!

JEFFREY Wilson's salute to President Barney is a well-documented summary of our new president's many attributes and an excellent introduction for those who are not well acquainted with him.

The Medical Society of Virginia is indeed fortunate to have had the benefit of outstanding presidents, the most recent of which are Glenn Updike and Tom Hulvey. Bill Barney will join select company, and both he and the Medical Society of Virginia deserve it.

E.L.K., Jr.

The President

THE longer I am involved with organized medicine, the more I realize that the President of The Medical Society of Virginia has a very difficult job, a job more difficult in some ways than that of the President of the United States.

The President of The Medical Society of Virginia has only one year, not four or eight, to accomplish his goals and has far more limited resources than the President of the United States.

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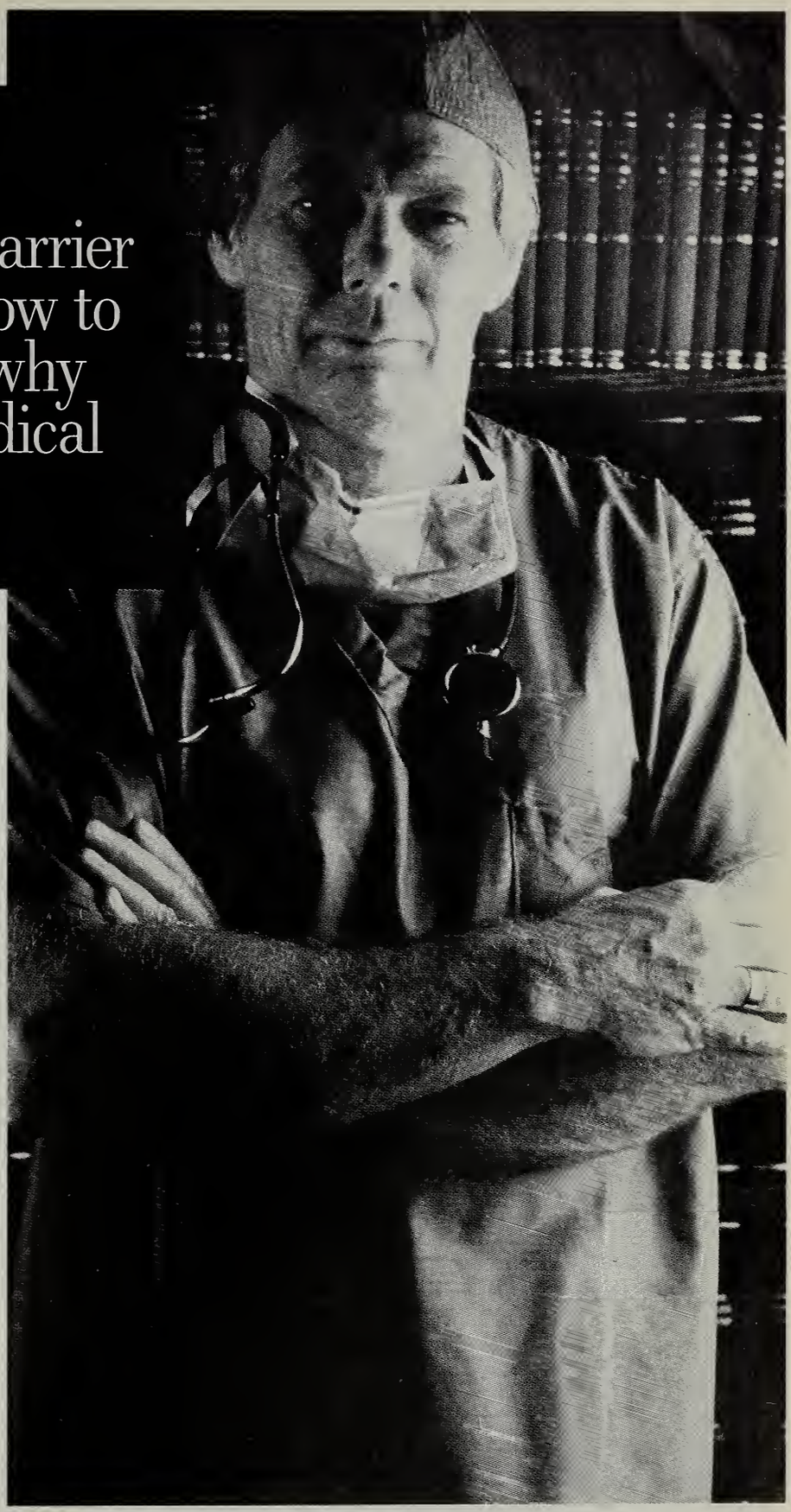

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OBITUARY

Memoir of G. G. Birdsong 1914-1989

By George J. Carroll, MD

Gordon Gilbert Birdsong, MD, 75, of Franklin, Virginia, a practicing physician of obstetrics and gynecology, died on July 6, 1989.

Dr. Birdsong was born in Pulaski, Tennessee, and was a 1935 graduate of the University of Tennessee, Knoxville, with a BS in chemistry. He graduated from the University of Tennessee Medical College, Memphis, in 1939. Following a three-year residency training program in obstetrics and gynecology, he practiced with the T.V.A. and American Cyanamide Company for six years and the Obstetrics and Gynecology H.C.H. Clinic in Oklahoma for four years before coming to the old Raiford Memorial Hospital in Franklin, Virginia, in 1953. For the next 32 years he practiced his specialty in Franklin and Southampton Counties until his death.

Dr. Birdsong was active in local and state medical affairs from the inception of his practice until his death. He was an active member of the Raiford and Southampton Memorial staffs, which he served as president. A member of the Tri-County Medical Society, he served on all of its committees and as president. Gordon was a delegate from Franklin for the Tri-County Society to the Medical Society of Virginia for some 20 years. He was an active member of the Southside Medical Society, which he also served as president. In these capacities he represented the Fourth District as vice-councilor to the Medical Society of Virginia from 1972-1974 and as councilor from 1974-1979.

Gordon was active in local affairs and was a former member of the Franklin Rotary Club. He was vitally interested in the American Red Cross Bloodmobile and was regional chairman of volunteers of the American Red Cross. He was instrumental in getting the Bloodmobile to this area. He was a 12-year member of the board of directors of Paul D. Camp Community College in Franklin and Suffolk and served as the body's chairman in 1981. He also initiated the first ob/gyn free clinic in the area.

Gordon will long be remembered by his many friends as an avid fisherman and as an outspoken gentlemen. For all of the above, he will be remembered by his many friends in the community and in medicine. Those of us who knew him better will remember him as a solid persuasive friend with humor and candor, devoted to medicine and his family, especially Laura, and Anne, his daughter.

May he rest in peace.

- **Claude E. Cooper, MD,** Annandale; George Washington University School of Medicine, 1940; age 77; died September 20, 1989. He was a general practitioner.

- **William Leicester Foster, MD,** longtime family physician in Roanoke; University of Maryland School of Medicine, 1945; age 67; died June 27, 1989.

- **Ralph Roy Landes, MD,** Danville; Rush Medical College, 1939; age 71; died October 5, 1989. He had practiced urology in Danville for 40 years.

- **John P. Mandanis, MD,** Arlington internist; Duke University School of Medicine, 1951; age 67; died October 5, 1989. He was a specialist in cardiovascular diseases.

- **Cullen M. McCoy, MD,** ophthalmologist in Norfolk for 45 years; Tulane University School of Medicine, 1927; age 88; died October 7, 1989.

- **Edith I. Miller, MD,** Petersburg radiologist; University of Colorado School of Medicine at Denver, 1933; age 94; died November 27, 1988.

- **Gorman Joseph Redding, MD,** general practitioner in Alexandria; Georgetown University School of Medicine, 1957; age 55; died October 8, 1989. He helped found Mount Vermon Hospital and was its chief of staff from 1977-1988.

- **Frank Andes Strickler, MD,** Roanoke psychiatrist; University of Virginia School of Medicine, 1932; age 81; died September 9, 1989.

News of the death of a Medical Society of Virginia member may appear in these pages in either or both of two ways: 1) a brief notice written by staff giving factual information; 2) a memoir contributed by a physician who knew the deceased peer and writes a personal account of his or her life. If the memoir is contributed before the brief notice is inserted, it is published at once; if after, it is set in type to be published as space permits.

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